MEDICAL REVENUE CYCLE SPECIALISTS

ILLINOIS PUBLIC HEALTH ASSOCIATION IPHA

Revenue Cycle Management 101

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Kem Tolliver, FACMPE, CPC, CMOM
CEO of
Medical Revenue Cycle Specialists

Your Speaker

Professional Experience Highlights:

- Author of "Revenue Cycle Management: Don't Get Lost in the Financial Maze" published by MGMA®
- Author of "Advanced Strategy for Medical Practice Leaders – Financial Management Edition" published by MGMA®
- MGMA® distinctions in, "Better Performing Practice" distinctions in Accounts Receivable & Collections
- Prior Chair of Government Affairs Committee and member at large for Board of Directors of MD MGMA
- Maryland General Assembly expert testimony supplier on healthcare and financial legislation
- Adjunct Professor of Revenue Cycle at Catonsville Community College
- Co-Host of RevDive Podcast hosted by Slice of Healthcare Media
- National Presenter and Educational on Revenue Cycle Management, Practice Management and Coding

Education & Certifications:

- Dual B.S. degrees in Healthcare Administration (Summa Cum Laude) & Organizational Management (Magna Cum Laude)
- Fellow American College of Medical Practice Executive (FACMPE), Certified Professional Coder (CPC), Certified Medical Office Manager (CMOM)

Professional Affiliations:

- Faculty Member of Practice Management Institute and Member of CMOM Certification Program Committee
- Past President of Prince George's County, Maryland chapter of AAPC
- Co-founder of Prince George's County Practice Manager's Association
- Serves on the Novitas JL Carrier LCD Advisory Committee
- Serves on the MGMA Evaluation and Management Strategy Committee
- Served on the Board of Directors for Laurel Regional Hospital from 2017-2018
- Served as a Mentor for the Prince George's County Public School's 2018 PTECH Health Innovation Program
- Served on the Totally Linking Care-Maryland Advisory Council

Awards & Recognitions:

- State of Maryland Governor's Volunteer Service Certificate for 2015-2018
- Nexus Health, Fort Washington Medical Center nominated her for the 2016 Community Health Award
- MD MGMA's 2016 Outstanding Service Award
- Heart to Hand, Inc. 2019 Heart of Gold Award for 501(c)(3) community-based public health medical practice leadership

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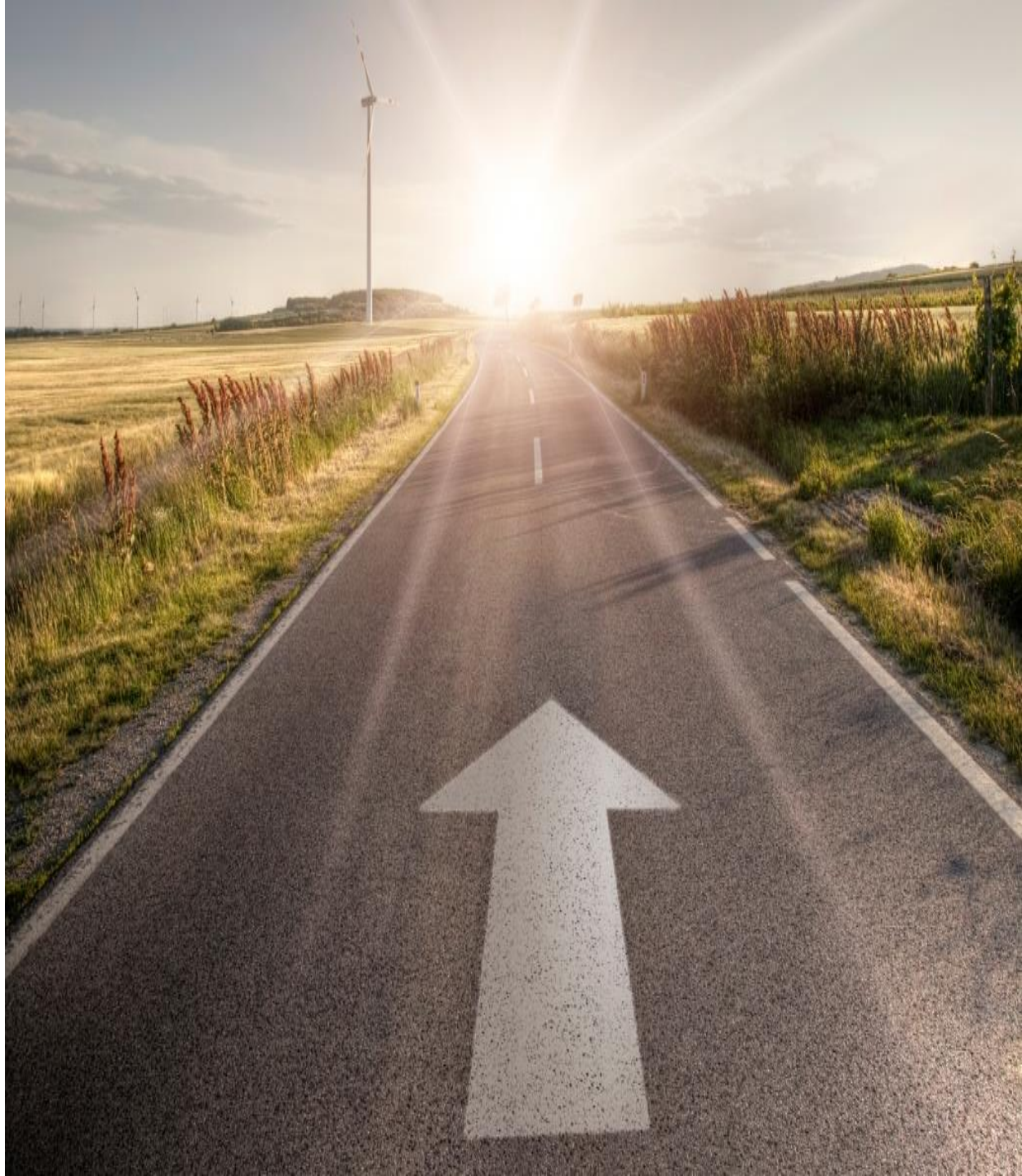
Abstract

Revenue Cycle Management impacts all aspects of a healthcare entity's ability to be paid for services and capability of delivering high quality care.

Participants of this session will learn of the foundational components of the Revenue Cycle and map current processes to best practices.



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Learning Objectives

Objective 1	Objective 2	Objective 3
Define and examine the four quadrants of the revenue cycle	Examine key workflows within each revenue cycle components	Map revenue cycle components to clinic workflows

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Revenue Cycle Overview

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What is Revenue Cycle Management?

The Revenue Cycle is comprised of all components that impact a healthcare organizations ability to be paid for services rendered. These components include but are not limited to patient intake, documentation of services, claims submission, payment posting, denial management and reporting.

Revenue Cycle Management is the oversight of these combined components. RCM is critical to the sustainability of all organizations that provide healthcare services.

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Key Revenue Cycle Terms and Definitions

Accounts Receivable	• Amounts in A/R are outstanding balances due payable to the organization. This can include balances due from patients as well as from insurers.
Allowable Amount	• The maximum contracted amount that is paid by a health insurance company for a covered service.
Appeal	• Request for reconsideration and review for a claim which was not paid.
Assignment of Benefits	• The process that a beneficiary turns over payment of services to another organization on their behalf; thereby removing them from the medical billing process.

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Key Revenue Cycle Terms and Definitions

Balance Billing	• Occurs when a patient is billed for the balance between the providers charge amount and the payers allowed amount.
Charge Description Master	• Comprehensive list of CPT/HCPCS codes and description of services charges for healthcare.
Claim Adjustment Reason Codes (CARC)	• Communication of why a claim or services was paid differently than it was billed.
Claim Control Number (CCN)	• 14-digit number assigned to each claim in the Medicare system. All numbers in sequence serve a purpose.

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Key Revenue Cycle Terms and Definitions

Clean Claims Act	• State specific law requiring insurance companies to pay claims to provider that have no errors or incomplete documentation in a specified amount of time.
Clearinghouse	• Intermediary between the practice and insurance company that allows for bi-directional information flow to include but not limited to claims edits and eligibility information.
Co-Insurance	• The remaining balance that is the patient's responsibility after a deductible has been met (i.e. 80%/20%)
Co-Payment	• Out of pocket expense for healthcare services assigned by the patient's insurance company. Costs may vary based on type of service (i.e. PCP, Specialist, ER, Urgent Care).

Key Revenue Cycle Terms and Definitions

Excluded Services	• Healthcare services that are not covered under the patients insurance plan.
Explanation of Benefits	• Summary of services provided, payments made, non-payments, denials, adjustments and patient financial responsibility.
Remittance Advice Remark Codes (RARC)	• Used to provide additional explanation for a CARC; Supplemental & Informational
Retraction	• Insurance withdrawing funds for claims already paid based upon further claims consideration.

Key Revenue Cycle Terms and Definitions

Timely Filing	• The amount of time granted to submit a claim after the date of service.
Unbundling	• Billing individually for CPT/HCPCS codes that should be included in a code set.
Utilization Review	• Criteria used by insurance companies to compare health status with care to reduce improper payments and utilization of resources.
Virtual Payments	• Payment method that replaces checks & EFTs with a credit card. Usually includes a finance fee that is subtracted from the allowable amount.

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Key Revenue Cycle Terms and Definitions

Code Set 270	• Query sent by providers for patients healthcare benefits info to insurance.
Code Set 271	• Response from insurance back to provider on patients benefits info.
Code Set 835	• Electronic Remittance Advice (ERA) from Payer to Provider.
Code Set 837	• Electronic submission of healthcare claims from provider to insurance.

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Skills Found in Successful Revenue Cycle Team Members

- Attention to Detail
- Problem Solving
- Insurance Knowledge
- EMR/PM Software Knowledge
- Patient Engagement
- Care Coordination

Who on Your Team is Responsible for these items?
Counsel patients on the details of their insurance benefits and referral obligations at the time of service.
Performs insurance verification and pre-authorization on required services during pre-registration.
Verify and obtain all HMO eligibilities and referral requirements prior to services being rendered.
Documents all eligibility and referral requirements for use during registration/intake.
Update patient account and superbill with new information received during eligibility checks.
Adheres to contracted payer reimbursement guidelines and Federal and State regulations related to HIPAA security and patient privacy compliance.
Professional etiquette is used and accurate documentation is taken and noted in patients account.
Communicate insurance eligibility information to billing and care coordination team.

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CONGRATULATIONS!

WELCOME TO THE REVENUE CYCLE MANAGEMENT TEAM!!

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Image Credit: BAREINTERNATIONA.COM

Overview of the Full Revenue Cycle

Image Credit: Pinstake.com

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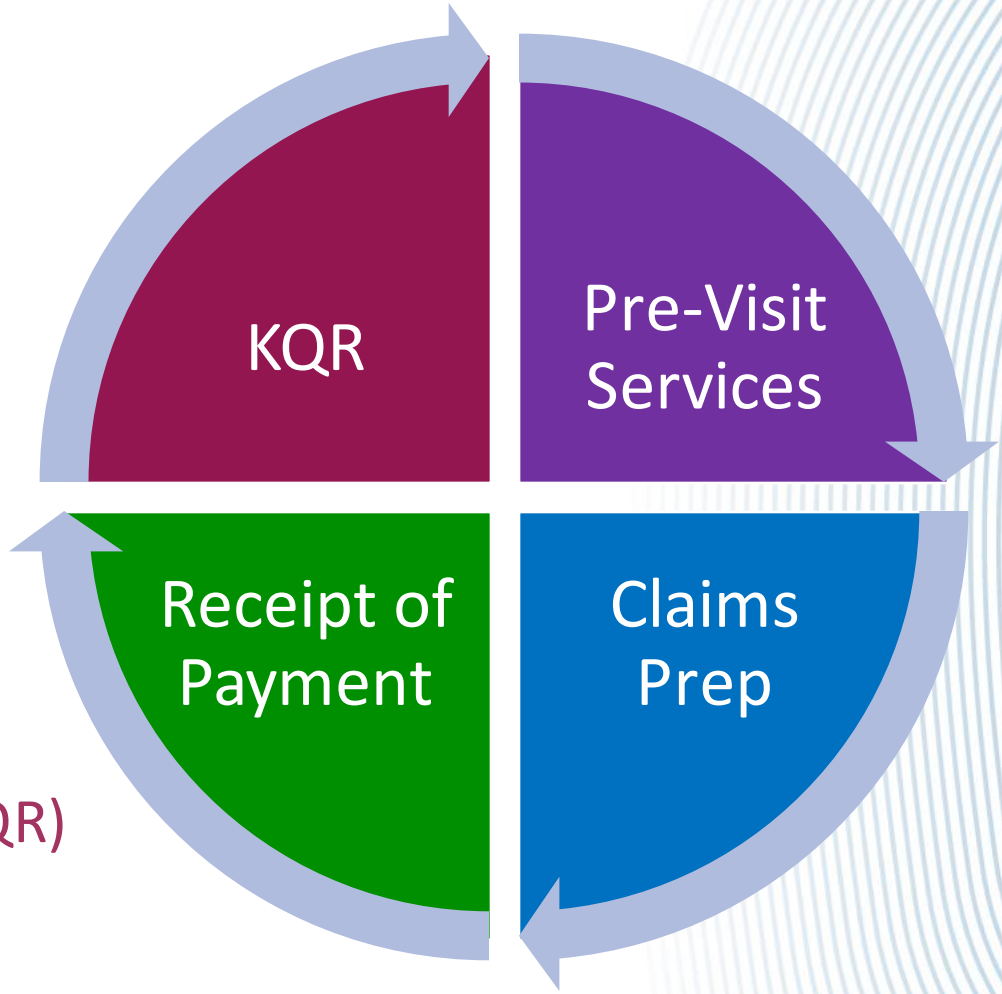
The 4 Quadrants of the Revenue Cycle

1st Quadrant Patient Access & Pre-Visit Services

2nd Quadrant Claim Preparation (Mid-Cycle)

3rd Quadrant Payment Oversight

4th Quadrant KPIs, Quality Programs & Reporting (KQR)



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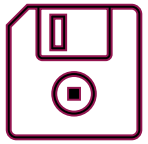
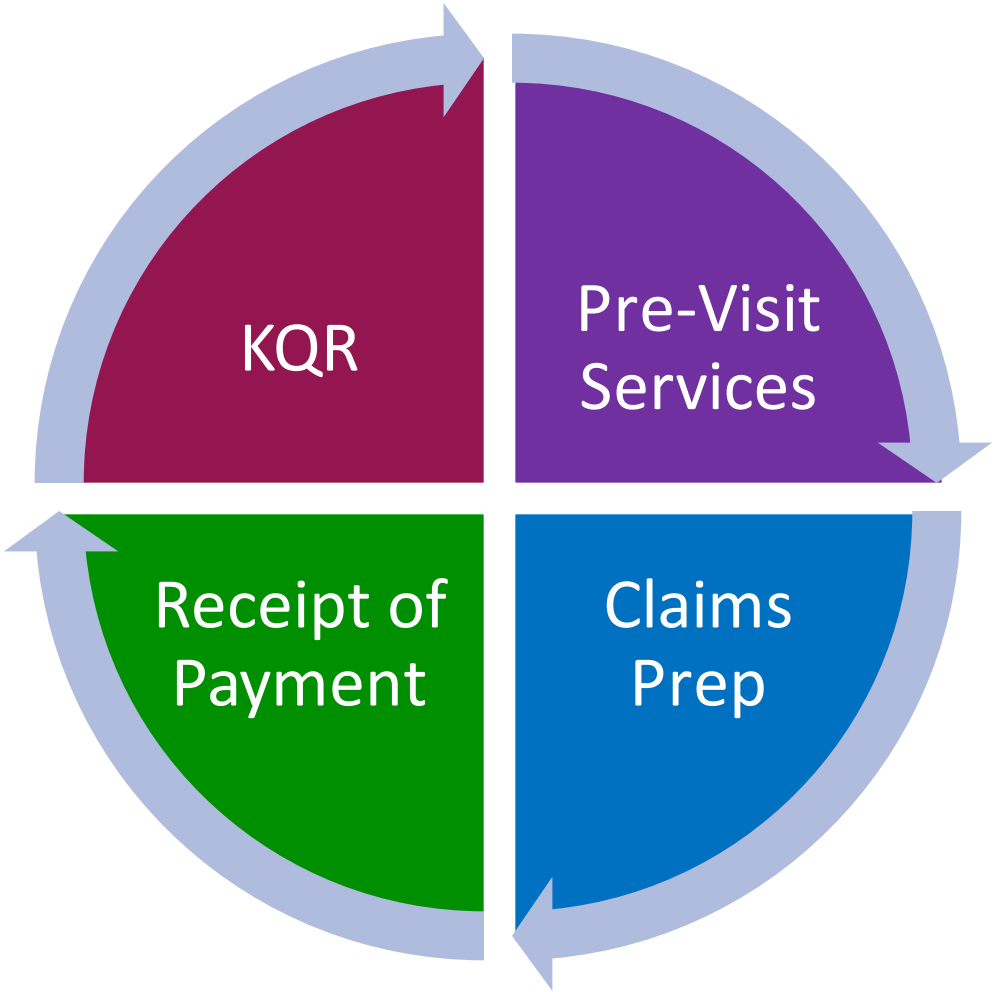
Data Collection from Revenue Cycle Sources

Based on information from **your data**



Based on information from **the payer**



Based on information from **the patient**

Based on information from **the provider**

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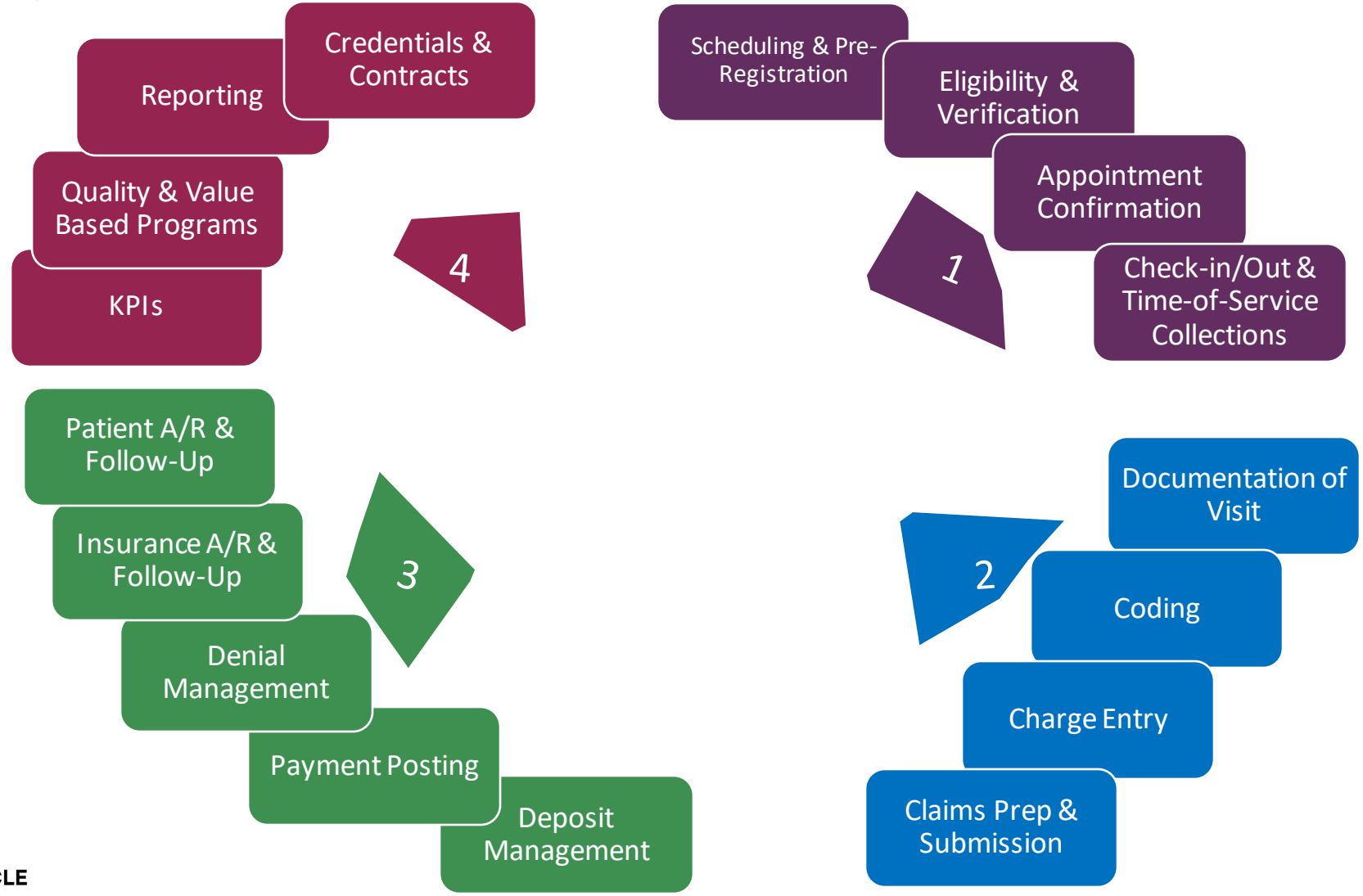
Revenue Cycle Components within Each Quadrant



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Revenue Cycle Quadrants and the highlighted Components with Key Workflows

Image Credit: Pinstake.com

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1st Quadrant: Pre-Visit Services

Based on information from **the patient**

Key Components

- Pre-Registration & Scheduling
- Eligibility & Verification
- Appointment Confirmation
- Check In/Out & TOS Collections

Gathering vital patient demographic information that will be used to populate EHR for patient's record.

This information is then used for care delivery (i.e. RX, testing, progress notes, referrals, hospitalization) as well as billing the necessary funding source or insurance.

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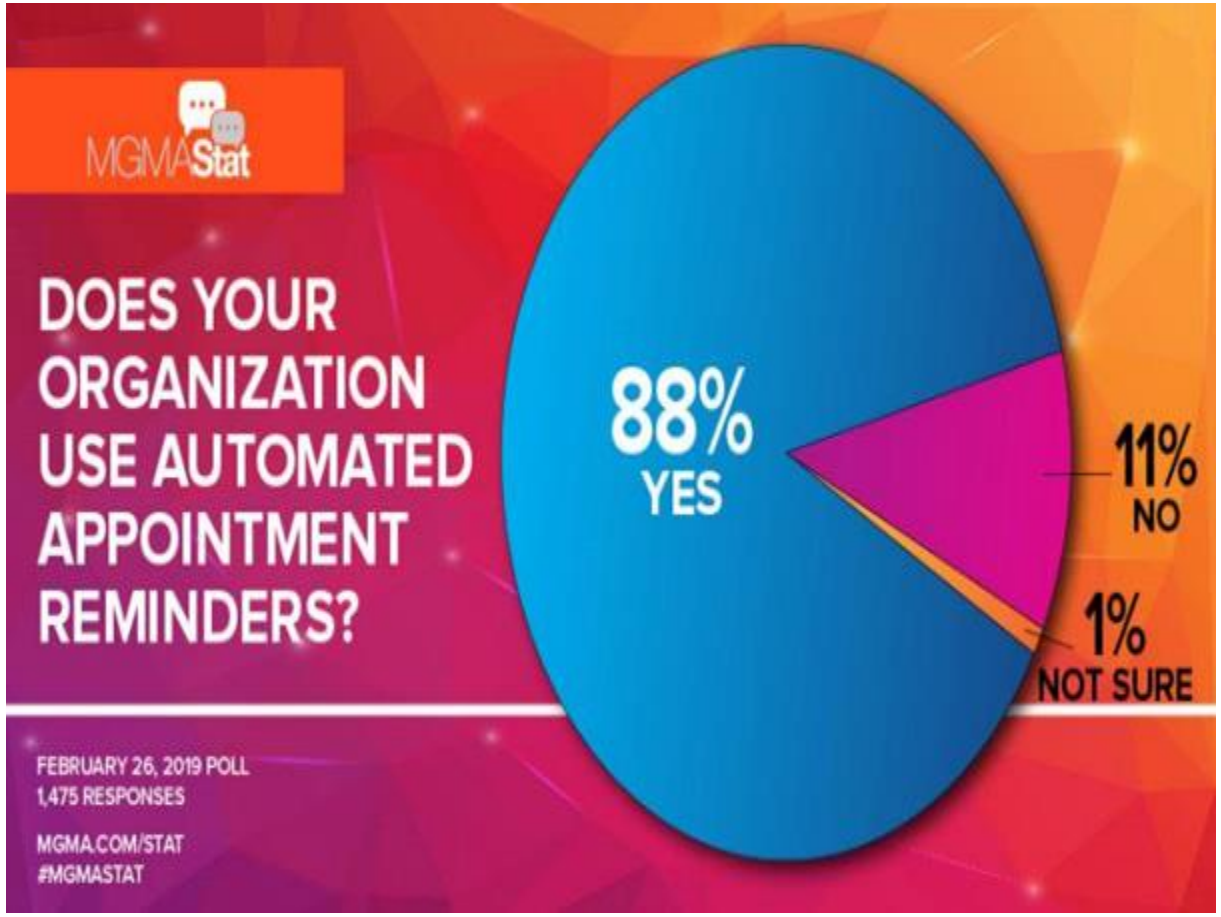
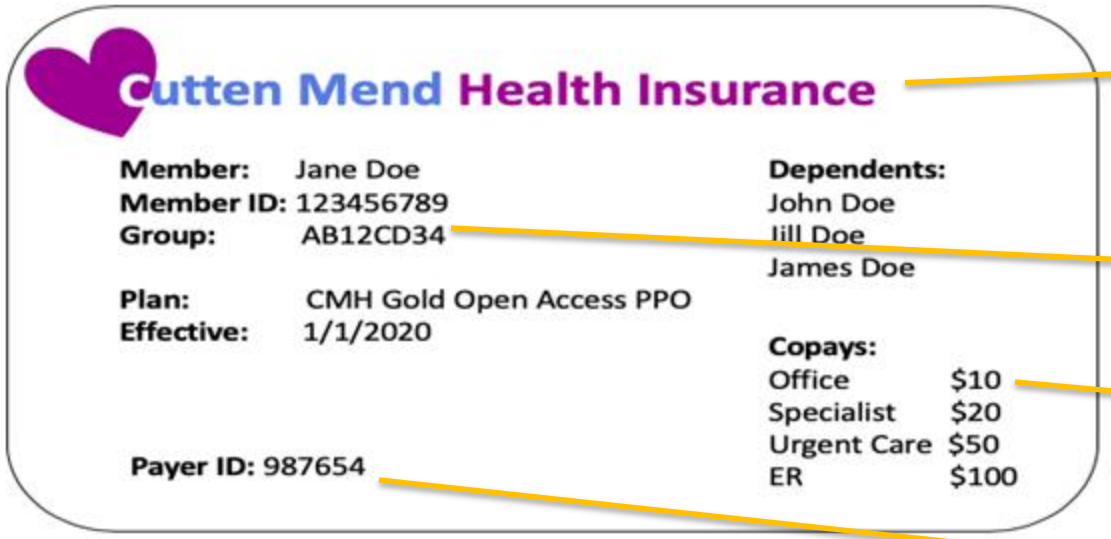
Automated Appointment Confirmation

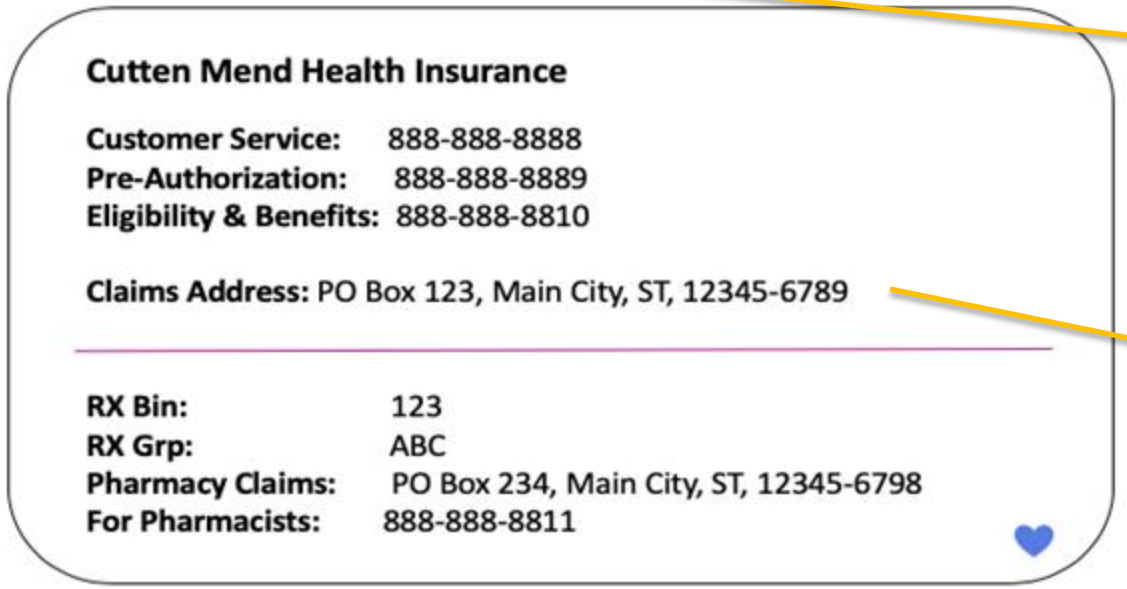


Manual Confirmations
The office staff, or a contracted third-party, contacts the patients directly via phone to confirm their upcoming appointment.

Electronic Confirmations
The scheduling system, usually the PM system generates automated reminder calls, texts, or emails that are sent to patients to confirm their upcoming appointment.

Insurance Card Data Elements





- Payer Name
- Member Name
- Member ID Number
- Group Number
- Plan Type
- Office Copayment
- Payer EDI #
- Eligibility & Benefits
- Claims Address

Graphic Credit: *Revenue Cycle Management Don't Get Lost in the Financial Maze*

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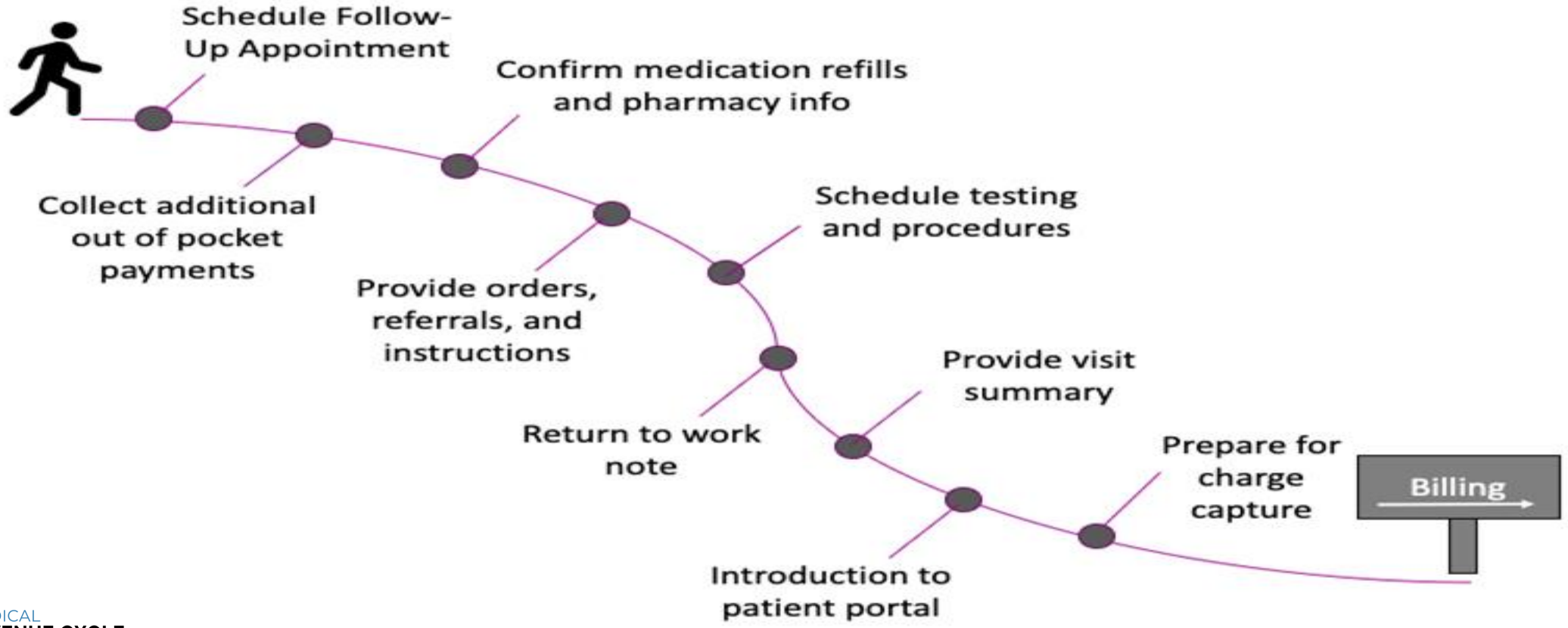
Improving the Check-Out Process

There are so many opportunities within the Revenue Cycle to improve workflows and patient interactions to improve the billing and care delivery processes. Automation within check-out is the last opportunity during the patient encounter to engage with them directly.



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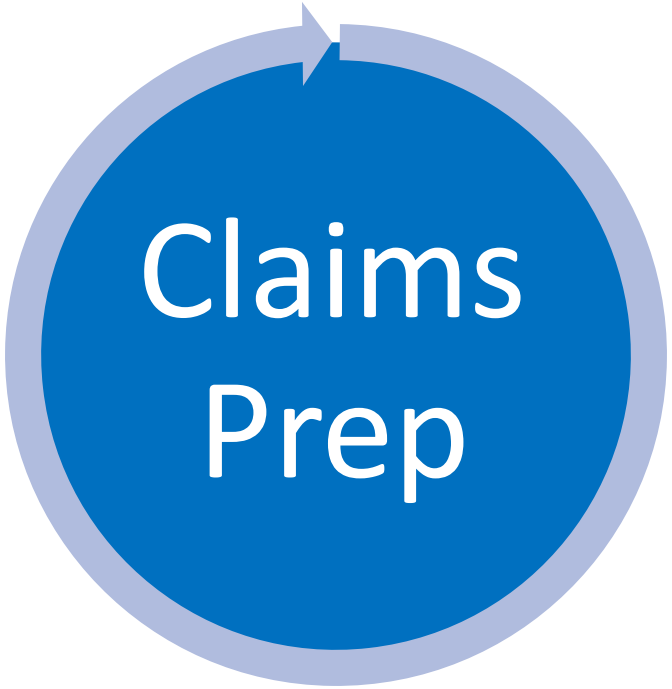
Graphic Credit: © MGMA.S.Moheiser.K.Tolliver: *Revenue Cycle Management Don't Get Lost in the Financial Maze*

2nd Quadrant: Claims Prep

Based on information from **the provider**



Key Components

- Documentation of Visit
- Coding
- Charge Entry
- Claims Prep & Submission

Data received from patients is used by providers for the development of treatment plans and selection of appropriate diagnoses. This information is translated into code sets which is reviewed for accuracy prior to submitting claims.

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EHR Documentation as the Source of Truth

Notes should answer these questions

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Clean Claim Data Elements

GOAL is 90% Clean Claims Rate

Subscriber ID# / Group #	Patient Name, DOB & Gender	Organizational NPI #
Date of Service	Place of Service Code	CPT / HCPCS/ ICD-10-CM Modifier
Rendering Provider NPI#	Correct Taxonomy Code	Tax ID#

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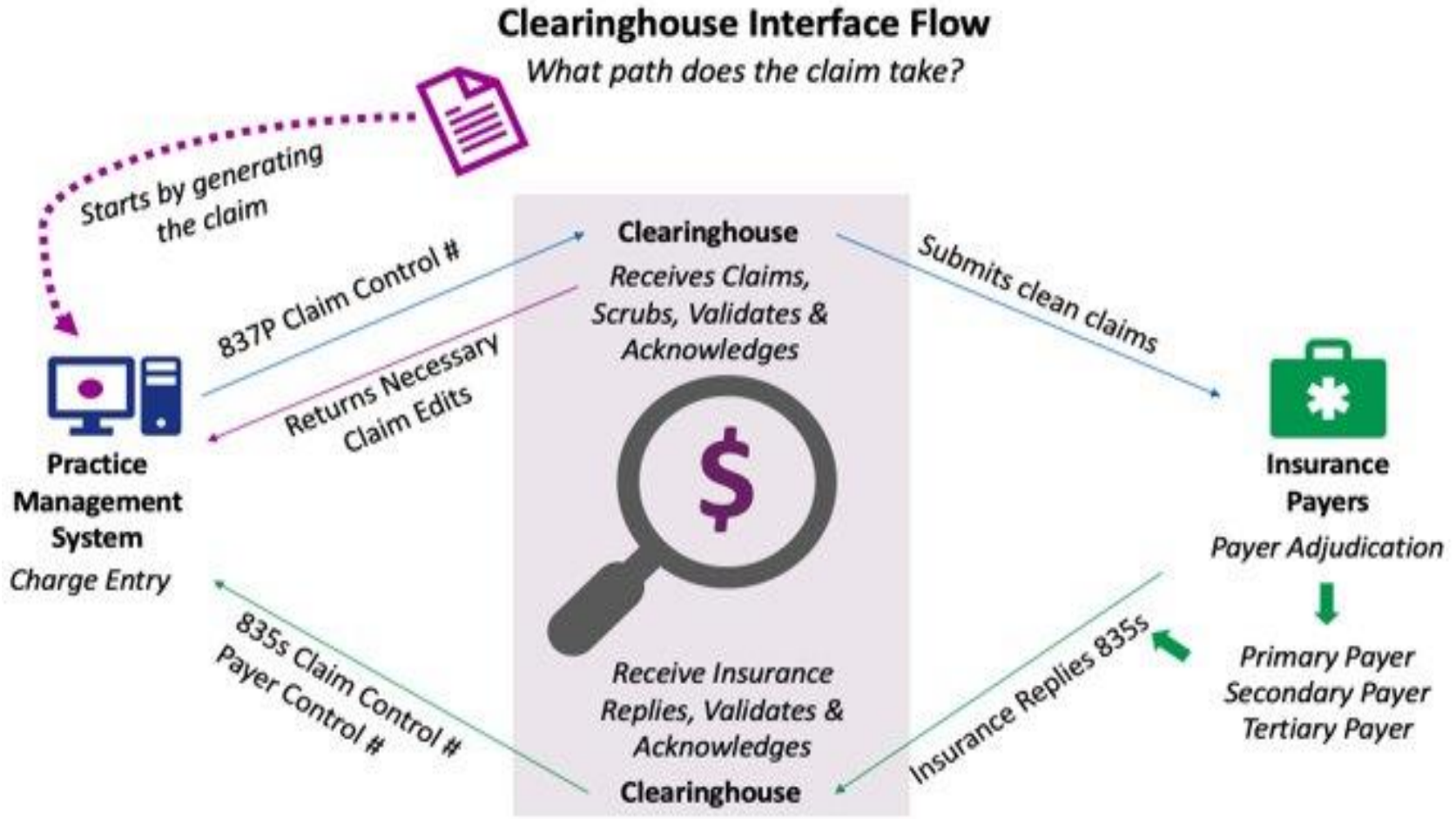
Clearinghouse Utilization



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3rd Quadrant: Receipt of Payment

Based on information from **the payer**

Key Components

- Deposit Management
- Payment Posting
- Denial Management
- Insurance A/R Follow Up
- Patient A/R Follow Up

This quadrant is our opportunity to hear back from insurance companies to see if we've followed their payment guidelines. We can correct errors and avoid patient's getting unnecessary bills. It's also a good idea to educate patients on their financial obligations to minimize care avoidance.

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Electronic Remittance Advance (ERA) Data

Cutten Mend Health Insurance

Electronic Remittance Advice

Patient Provider	DOS	Proc	Mod	Billed	Allowed	Pt Resp	Paid	Remark
Al. Caholic Dr. Yoda	1/1/2021	99213		100.00	80.00	16.00 10.00	54.00	PR-2, PR-3, CO-45
	1/1/2021	96372	25	25.00	8.00	2.00	6.00	PR-2, CO-45
			TOTAL	**125.00**	**88.00**	**28.00**	**60.00**	

Remark Codes

PR-2 Patient Coinsurance
PR-3 Patient Copay
CO-45 Charge exceeds maximum allowable

Payment: CHECK
Tracking#: 123456
Date: 1/31/2027

Graphic Credit: *Revenue Cycle Management Don't Get Lost in the Financial Maze*

Common Denial Types

- Administrative Denials
  - Outlined in the participation agreement and are administrative rules that were not followed

❑ Missing Prior-Authorization
❑ No Benefits

- Clinical Denials
  - Improper use of CPT, HCPCS or ICD-10-CM codes and failure to prove medical necessity for care delivered and reimbursed

❑ Not Medically Necessary
❑ Incorrect Diagnosis Code

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Denials vs Non-Payments

Denials

- Denied for No pre-authorization/Referral
- Denied as not financially responsible
- Denied as not a covered service
- Denied charge/procedure as bundled
- Denied for untimely submission

Non-Payments

- Denied pending receipt of medical records
- Denied due to missing/inaccurate data
- Denied due to coding issues
- Denied due to demographic information
- Denied secondary payment pending receipt of EOB from primary insurance

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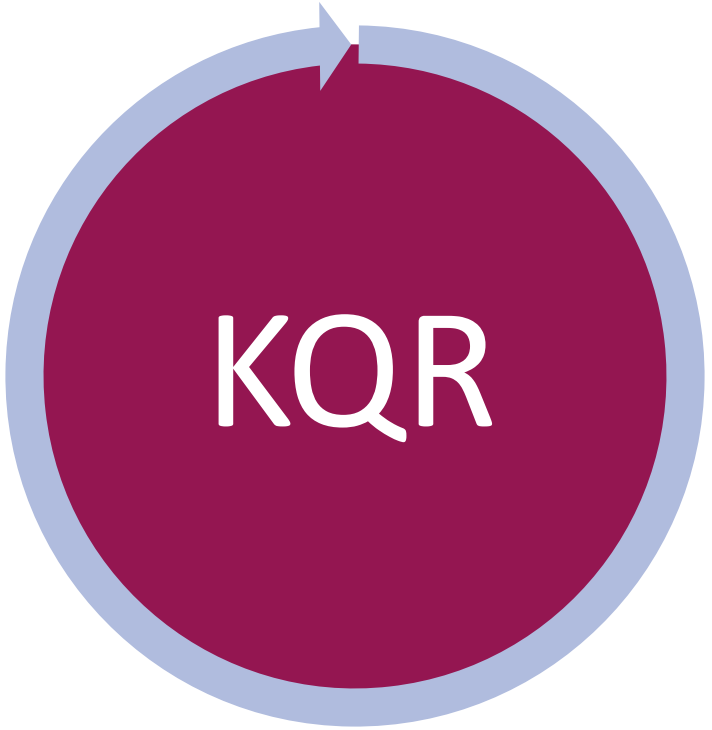
4th Quadrant: KPIs, Quality Measures, Reporting

Based on information from **your data**



Key Components

- Select and Monitor Key Performance Indicators (KPIs)
- Quality & Value Based Programs
- Analysis of Reports and Data Trending

Key Performance Indicators (KPIs), Quality Programs & Reports – KQR is the information we have in our software system based on the information we've received form all stakeholders. We want to analyze this data to identify care opportunities for our patient populations. We can use this information to create wellness campaigns and targeted care delivery.

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Revenue Cycle Management Software Features

Electronic Medical Record (EMR)

- Progress Notes
- External Records
- Lab/Radiology/HIE Interfaces
- ePrescribing
- CPT and Diagnosis Code Search
- Patient Portal
- Clinical Decision Support (CDS)

Practice Management Software

- Schedules
- Patient Demographic Data
- Billing Records
- Financial Reports
- Interface with Clearinghouse
- Quality Payment Dashboards
- Charge Description Master

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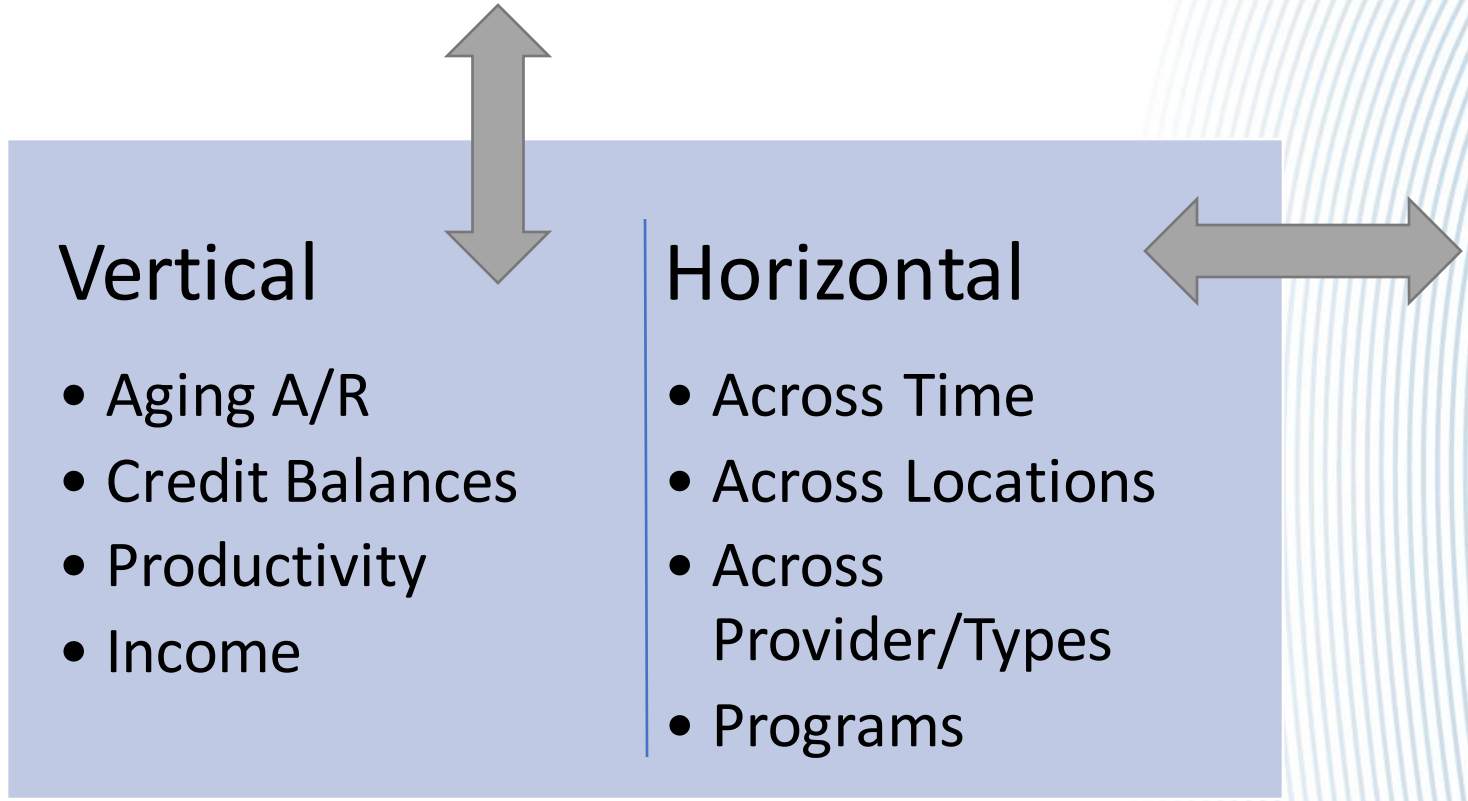
Key Performance Indicators (KPIs)

"Indicator" means that the information you have at hand isn't final or full but can help inform efficient decision-making.

KPIs can also help course-correct because they give a glimpse into the future.

Gabriel Tupula, CEO at Big Bang



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Key Performance Indicators

Payer Mix & Payer Income

- Participation
- Fee Schedule Negotiation

Provider Productivity

- Compensation
- Resource distribution

Patient Age & Gender

- Preventive Services
- Track supply & equipment needs

Denial Reason Codes

- Appeal success rates
- Trending payer guidelines

Gross Charges

- Compared to Allowable amount
- Analysis of CDM

Unique Patient Visits

- Staffing needs
- Exam room utilization
- Appointment optimization
- Visit wait time

Diagnosis Utilization

- Engage high risk patients
- Risk Adjustment

Referring Provider

- Patient sourcing
- Care Coordination

Adjustments

- Collections performance
- Enhance specificity of adjustment codes

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Charge Description Master Report

CPT Codes	Description	Charge
99203	NP L3	145.00
99204	NP L4	220.00
99205	NP L5	250.00
99213	Estab L3	100.00
99214	Estab L4	125.00
99215	Estab L5	150.00
93000	EKG w/Interp	50.00
94010	Spiro w/TC mod	50.00
99354	Prolonged / 1st hr	160.00
99490	CCM 20 min	75.00
99491	CCM 30 in	120.00
99495	TCM Med complex	200.00
99496	TCM High complex	300.00

Gross Charge List

- Created by the Clinic / Specialty
- Health Clinic selects CPT/HCPCS Codes
- Health Clinic set rates
- Use a Uniform CDM for all payers
- Update in PM Annually

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Insurance Fee Schedule Report

Analyzing your fee schedule helps to identify inconsistencies in payment, postings, underpayment trends and non-compliance of contract terms. Doing so also is the foundation for trending data that may be used for financial decision making.

CPT Codes	Description	Charge	Medicare	Payer #1	Volume	Grant Fund Alignment
99203	NP L3	145.00	117.01	125.00	400	
99204	NP L4	220.00	177.92	**Not listed**	300	
99205	NP L5	250.00	223.39	239.00	**2500**	
99213	Estab L3	100.00	80.46	70.00	750	
99214	Estab L4	125.00	117.58	119.00	700	
99215	Estab L5	**150.00**	157.40	160.00	1200	
93000	EKG w/Interp	50.00	18.65	25.00	500	
94010	Spiro w/TC mod	50.00	30.06	**60.00**	**1000**	
99354	Prolonged / 1st hr	160.00	139.94	**32.00**	125	
99490	CCM 20 min	75.00	44.88	38.00	89	
99491	CCM 30 in	**85.00**	88.83	100.00	**5**	
99495	TCM Med complex	200.00	177.78	150.00	275	
99496	**TCM High complex**	300.00	250.82	275.00	**2**	

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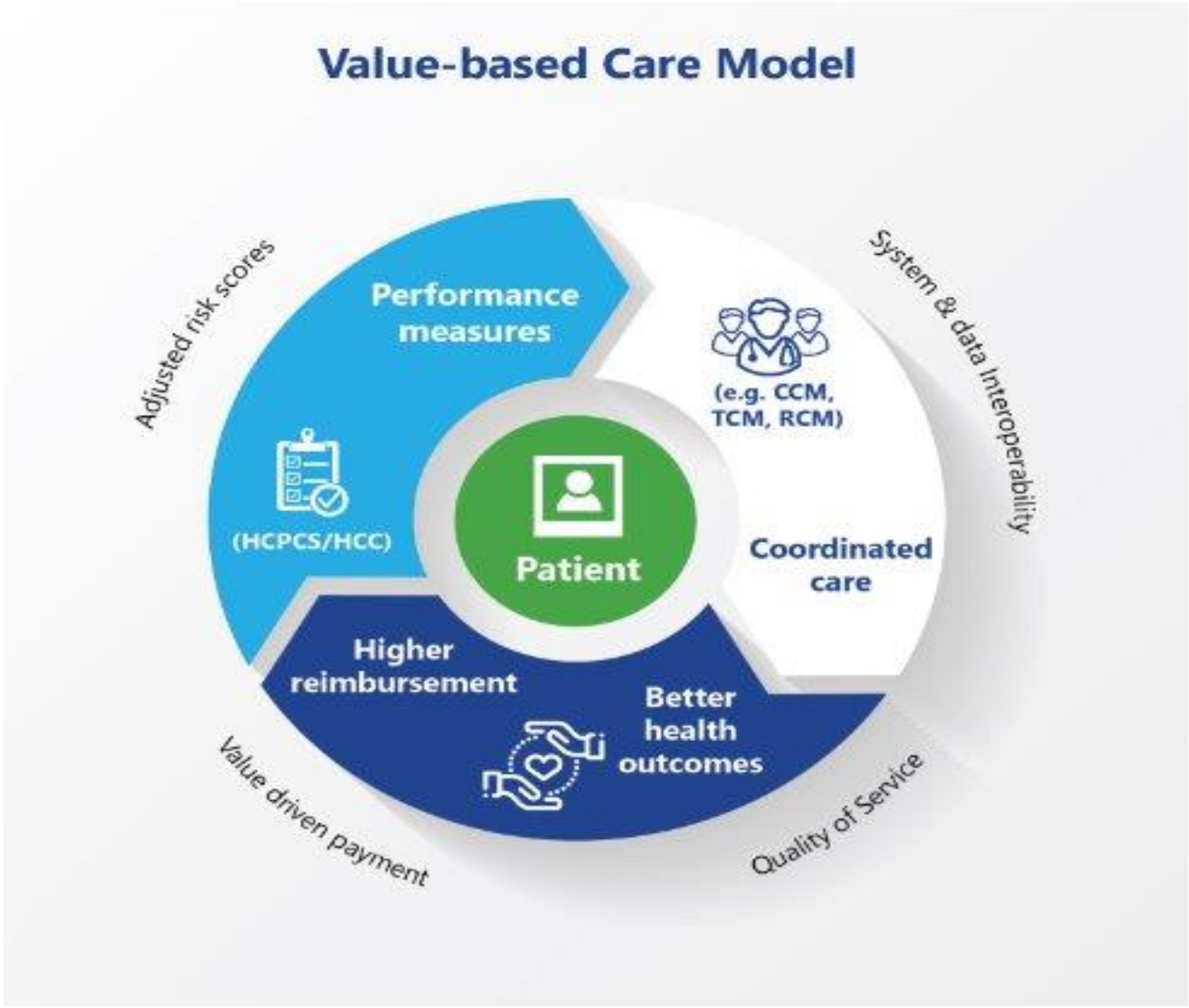
Value Based Payment Models



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Map Workflows to Rev Cycle

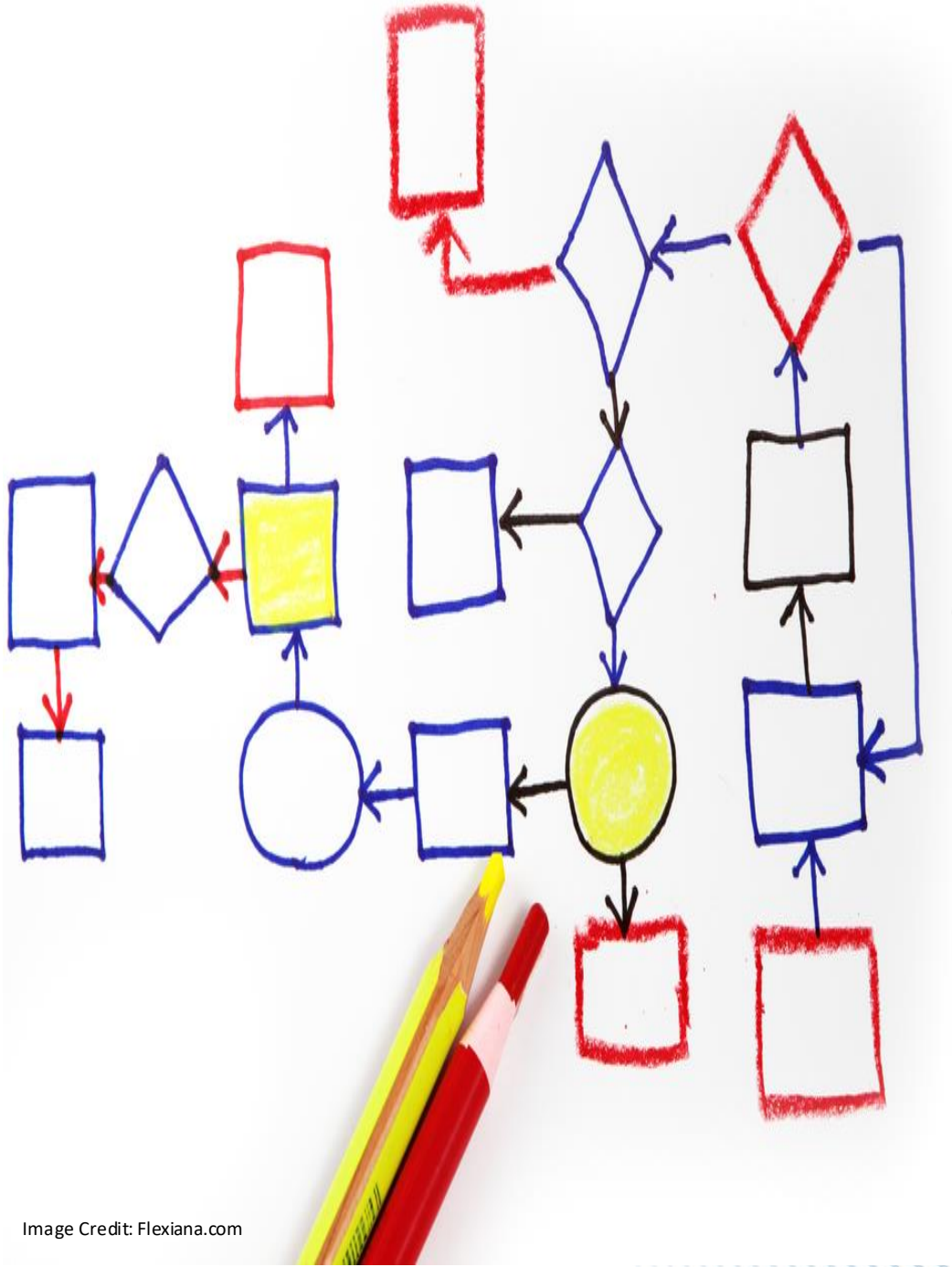

Image Credit: Flexiana.com

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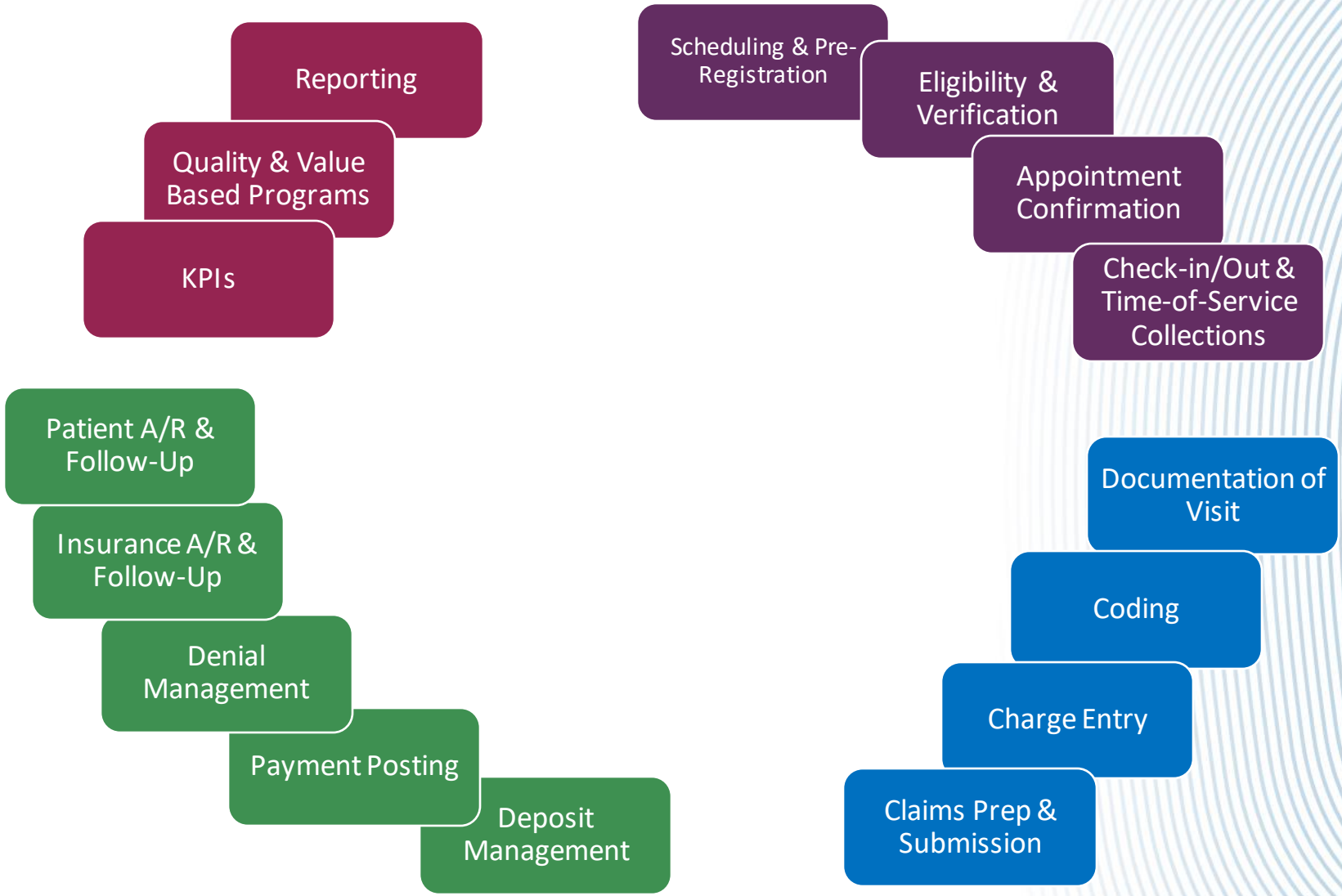
Mapping Workflows to Rev Cycle Components

- Patient gives ID and new patient paperwork
- Physician selects CPT/HCPCS codes
- Payer EOB/ERA is reviewed for denials
- Review end of month billing report
- Track gross charges



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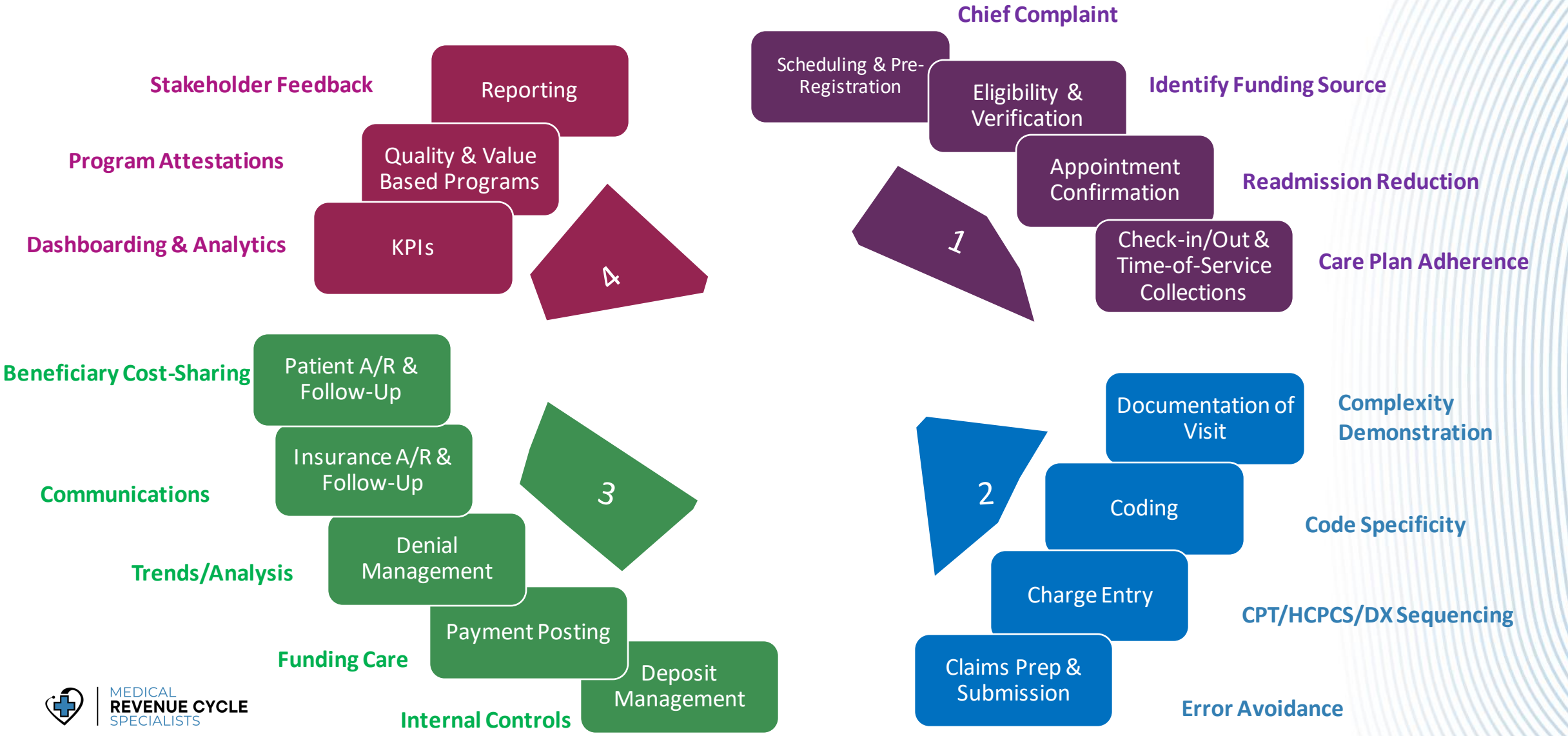
Mapping Social Determinants of Health to RCM



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Staying Compliant

Image Credit: NAMM.com

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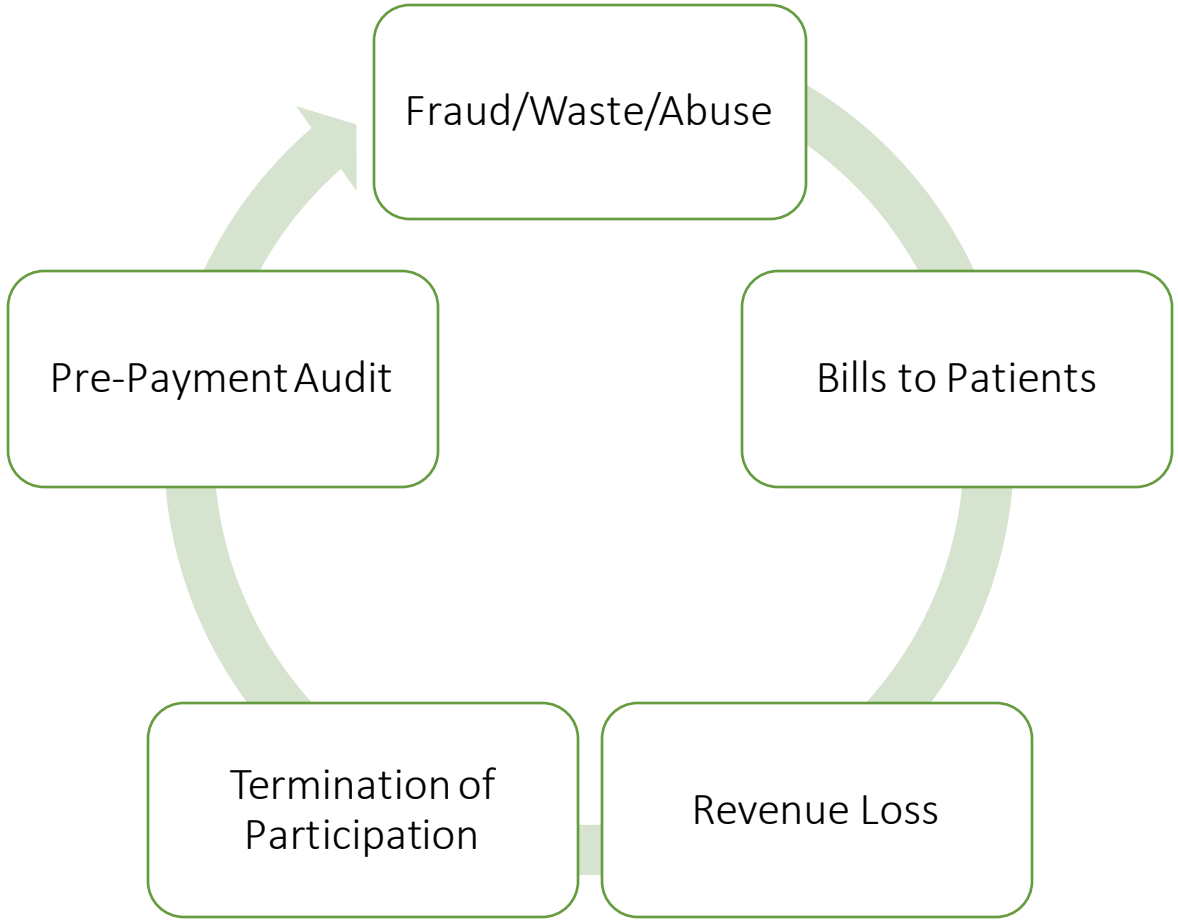
Consequences for Poor Revenue Cycle Management



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Payment Integrity Resource Optimization

It is the medical community's responsibility to interpret, understand and follow healthcare payment guidelines and provider enrollment requirements. Consistent interaction with online portals to ensure data accuracy and compliance with guidelines is critical to revenue optimization and compliance.

CAQH COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE

pecos.cms.hhs.gov

Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

X12

NPPES

National Plan & Provider Enumeration System

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National Healthcare Policy Development Agencies

Industry policies and mandates are compliance non-negotiables. To stay on top of and ahead of requirements, stay connected to the policy makers. Follow their guidance and share your experiences to advocate on behalf of your organization, patients and community.

World Health Organization

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

ONC
Office of the National Coordinator for Health Information Technology

Substance Abuse and Mental Health Services Administration
SAMHSA

NCQA
Measuring quality. Improving health care.

OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF STATE

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In Conclusion

- Dig into the Revenue Cycle areas that are most impacted by errors
- Identify reports to review and track progress
- Upskill staff to provide training and resources to new information
- Don't allow denials to go unchallenged, follow up with payers
- Review reimbursement guidelines to remain compliant

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Image Credit: wallpapercave.com

Bring on the Questions and Comments

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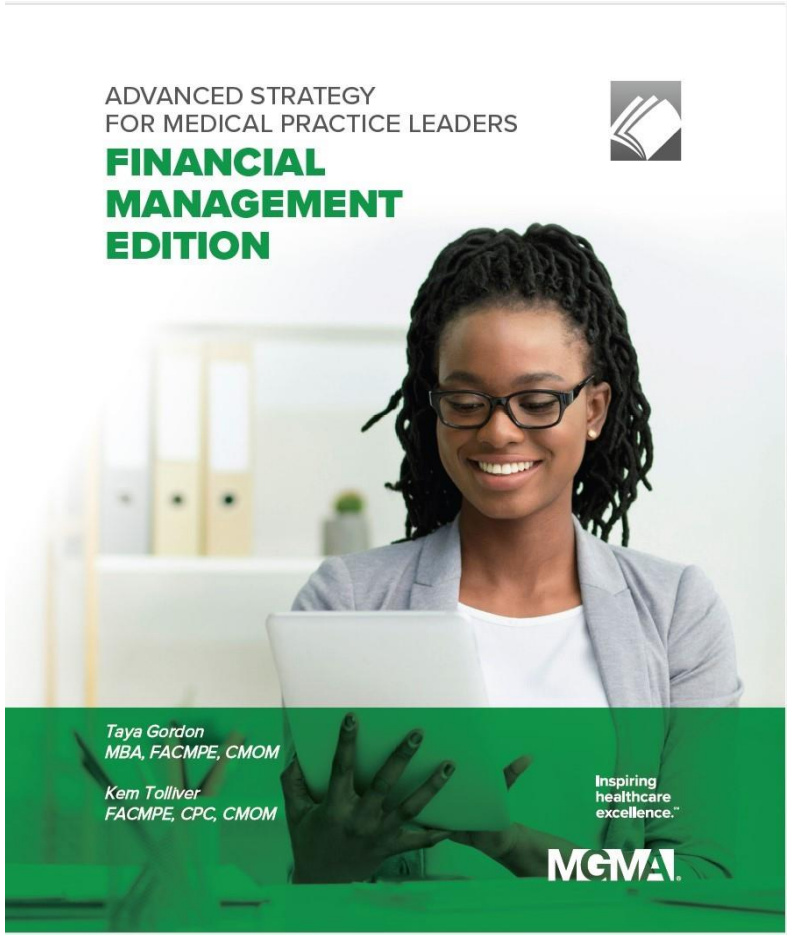
Resource Alert

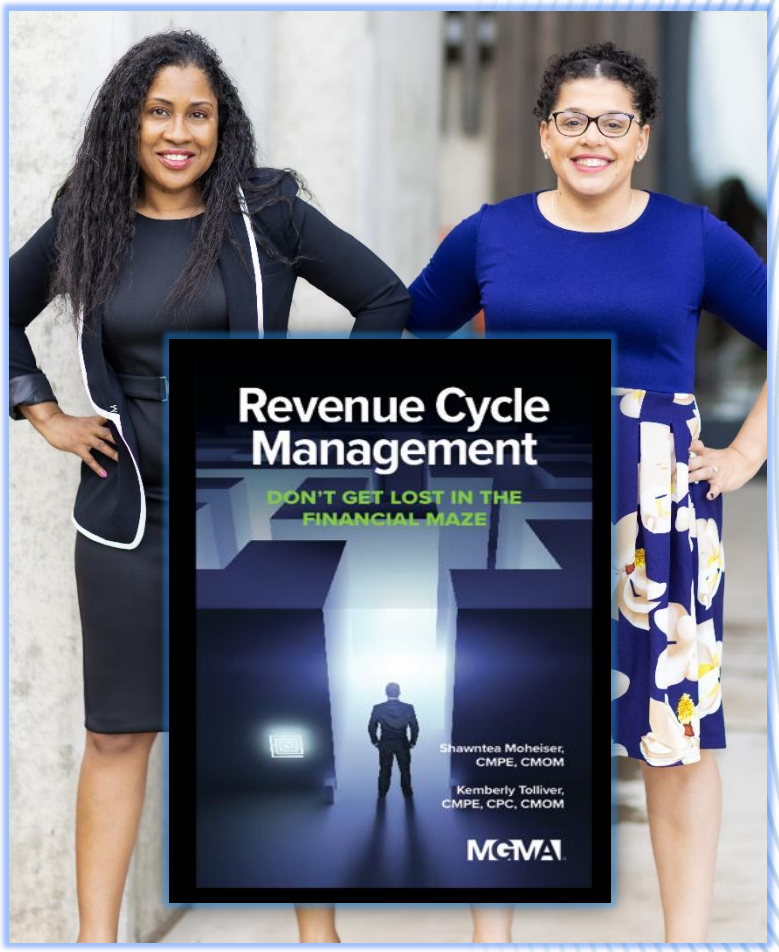
Co-Authors of MGMA's Revenue Cycle Management

Don't Get Lost in the Financial Maze + Advanced Strategy for Medical Practice Leaders

REVDIVE w/ Taya & Kem

Co-Hosts of the "Slice of Healthcare" Podcast:





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