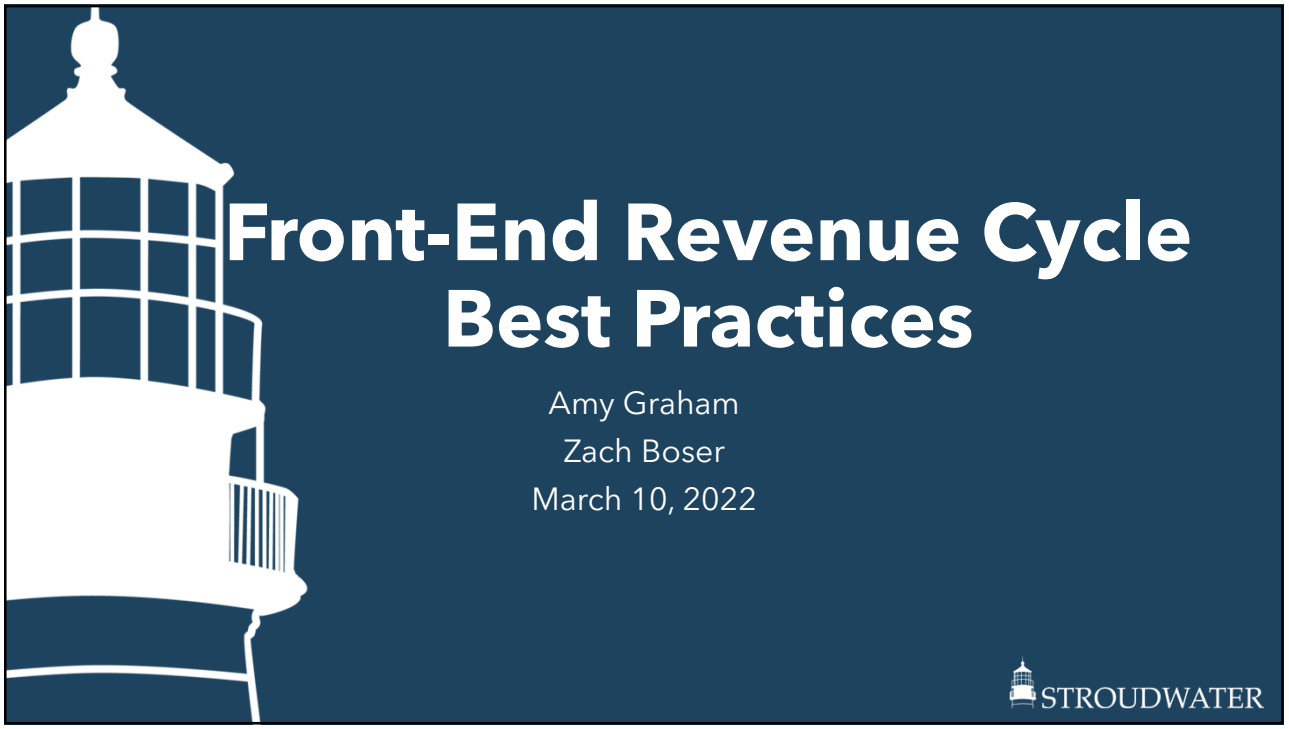
Front-End Revenue Cycle Best Practices
Amy Graham
Zach Boser
March 10, 2022
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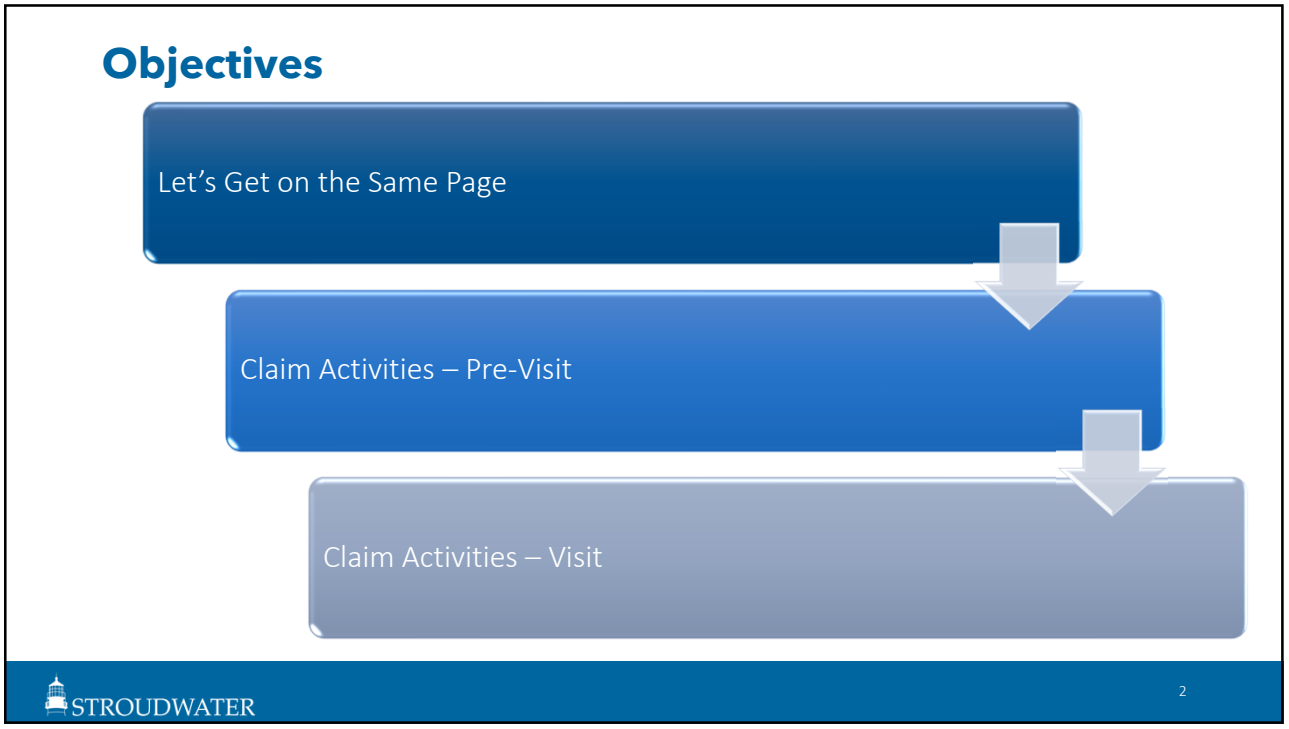
Objectives
Let's Get on the Same Page
Claim Activities – Pre-Visit
Claim Activities – Visit
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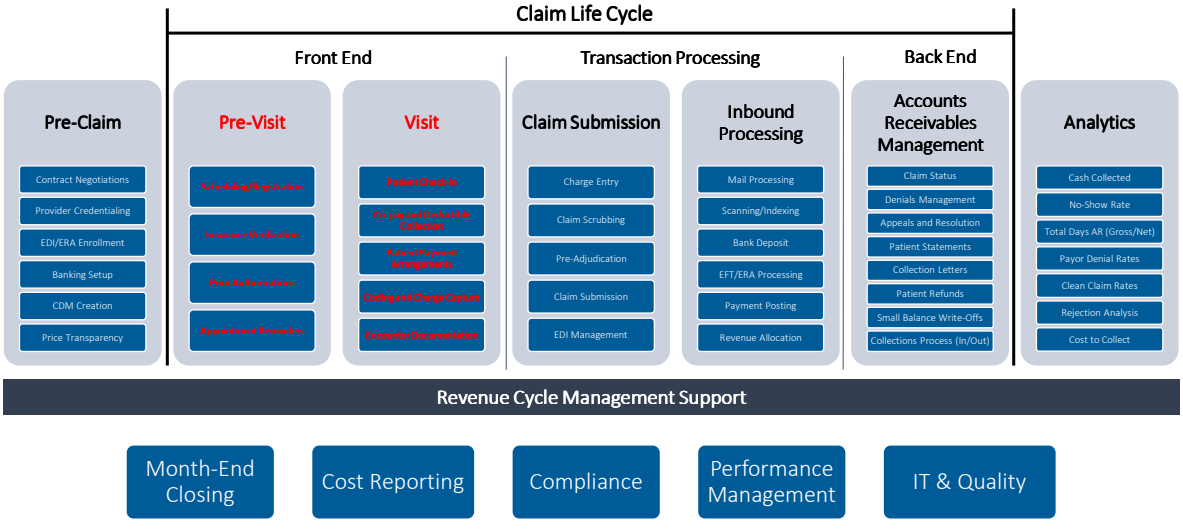
2

Revenue Cycle Management



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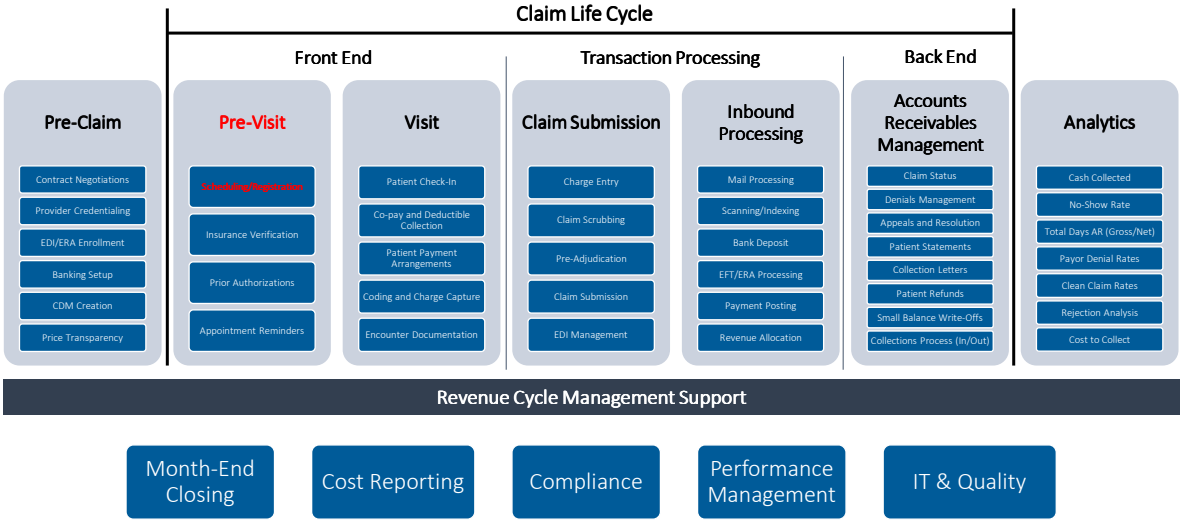

Scheduling/Registration

5 W's and an H
• Who? • What? • When? • Where? • Why? • How?

Questions to Ask
• **Who** is going to arrive? • **What** will they bring with them? • **When** are they going to arrive? • **Where** will they show up?   • (ER, registration, direct to floor) • **Why** are they coming? • **How** will they pay for services?

Scheduling/Registration – Best Practices

Put the patient at the heart of the revenue cycle process

Encourage revenue cycle staff to help build a better business for the hospital by acting as an agent for patient satisfaction and ultimately, loyalty and relationship management

Provide scripts for staff to follow to provide consistent, high-quality customer service

Create a pre-registration process to improve "day of" registration process and address noncovered services

Standardize data provided by referring physicians for scheduled services

Centralize scheduling for services so patients have one place to schedule all services and to inform patients of required documents and financial obligations

Scheduling/Registration – Best Practices (cont.)

Develop process to ensure physician order is available at the time of scheduling or process in place to obtain ahead of service date

Pre-register patient by obtaining and entering:

- Patient demographic information such as the patient's name, date of birth, address, telephone number, gender, and race
- Reason for the patient's visit or pre-ordered service
- Insurance carrier information such as the subscriber number, group number, subscriber demographic information
- Employer information
- Preferred pharmacy

Encourage physicians to use Centralized Scheduling services to help minimize patient dissatisfaction

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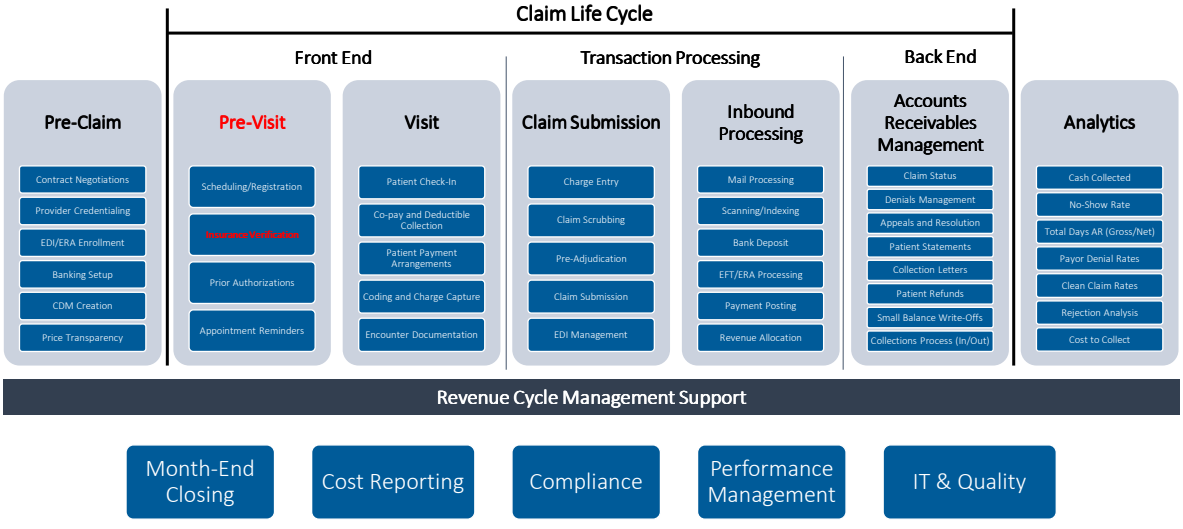

Insurance Verification

- Insurance verification is the first step toward receiving payment for services
- Claim denials have been steadily growing since 2016 up to 11% of all claim submissions in 2020
  - 86% of the claims are potentially avoidable
  - Proper insurance information streamlines the claim process
- Uses information obtained from the scheduling/ registration steps

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Source: Hospital Claim Denials Steadily Rising, Increasing 23% in 2020 (revcycleintelligence.com)

Insurance Verification – Best Practices

Verification should be run on all admissions including reference lab tests	Leverage the use of available online verification tools	Perform insurance verification on any secondary and tertiary insurance
Look for Medicare-aged patients presenting their "Red, White & Blue card" who are covered instead by a Medicare Advantage plan	Self-pay patients may qualify for state Medicaid coverage or charity care	Predetermine if services will meet medical necessity
Ascertain need for Prior Authorization	Identification of required co-payments, deductibles and previous balances	Track insurance verification rate to ensure process is efficient and effective • Total number of verified encounters/Total number of registered encounters

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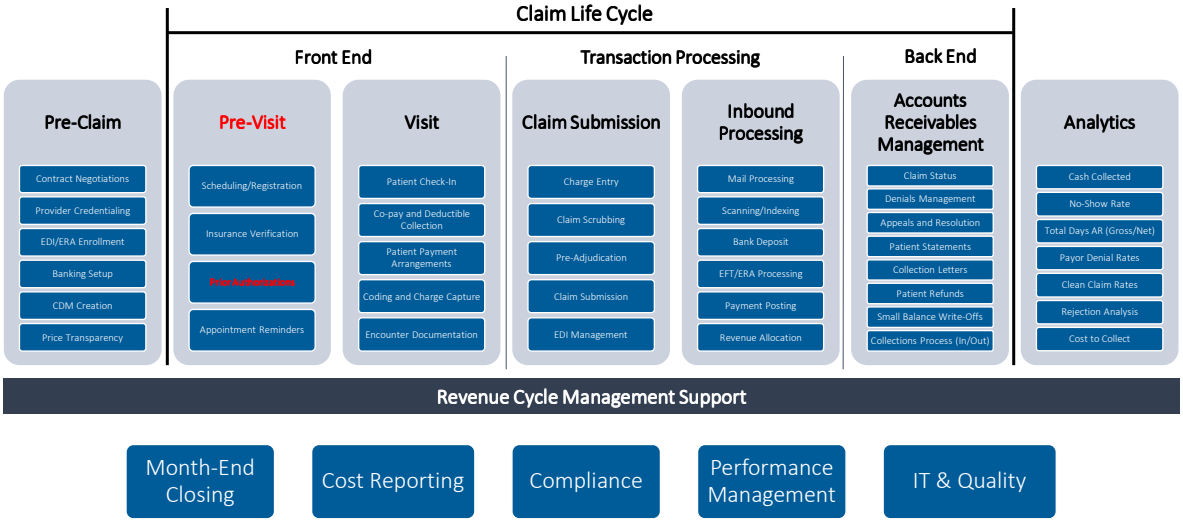


Prior Authorizations

"Prior authorization is a utilization management process used by some health insurance companies in the United States to determine if they will cover a prescribed procedure, service, or medication.

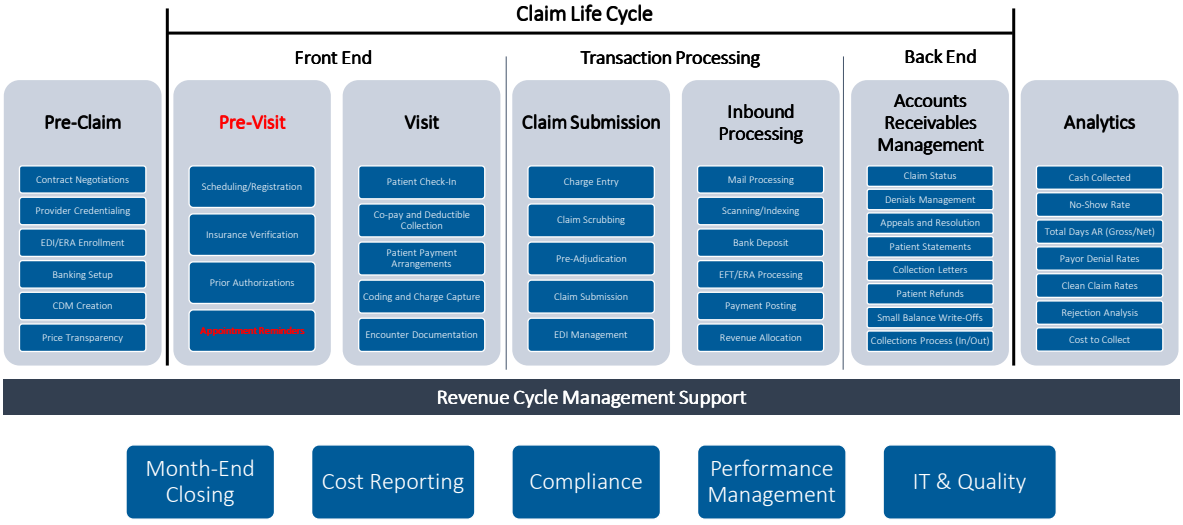
The process is intended to act as a safety and cost-saving measure although it has received criticism from physicians for being costly and time-consuming."

Source: Prior authorization - Wikipedia

Prior Authorization – Best Practices

- Develop a process that crosswalks insurance plans, CPT codes and authorization requirements
- Identify resources to perform Prior Authorization tasks, with backups trained to perform activities when primary resource is out of the office
- Establish specific policies around authorization management and detail scenarios for exception
- Develop processes between the Prior Authorization team and clinical services for Prior Authorizations needed once patient encounter/stay has begun (i.e., transfer to swing bed)
- Communicate outstanding cases needing pre-certifications to administration and appropriate clinical staff
- Implement checks for missing authorization for high-risk areas
- Trend and analyze missing and/or invalid authorization denials to identify potential changes to plan requirements

Revenue Cycle Management



Appointment Reminders

Potentially the hospital's *FIRST* interaction with the patient

- Confirm third-party coverage
- Discuss patient balances, point-of service collection policies
- Complete any outstanding paperwork
- Share what they can expect to happen on the day of visit
- Inform patient where to report at the hospital

Appointment Reminders – Best Practices

Provide	Provide scripts for staff to follow to provide consistent, high-quality customer service
Educate	Educate patients about their insurance benefits to include the amount of copayments, deductibles, and coinsurance that they would be responsible for paying at the time of service
Connect	Connect patient with financial counselors to support uninsured patients to complete assistance applications
Utilize	Utilize online services that will share information with patient via text or email
Provide	Provide good faith estimates to self-pay and uninsured patients
Tell	Tell patient the next step in their care and when they can expect that step to take place

Claim Activities – Visit

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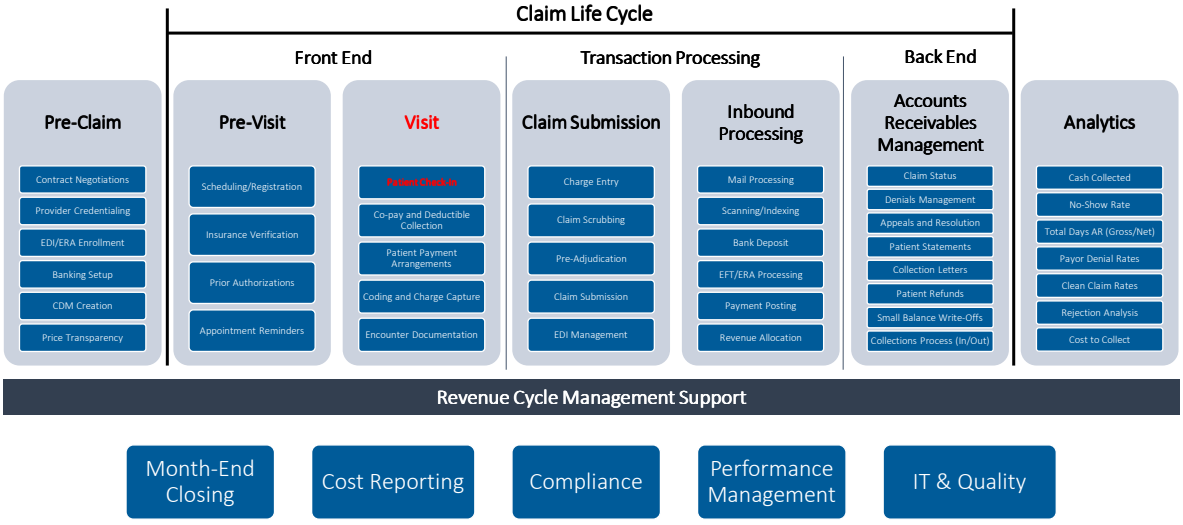
Revenue Cycle Management



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Registration

Sets the tone for the patient visit

Can be centralized in one area for all patients or in each ancillary department

Amount of time it will take will vary based on the success of scheduling and pre-registration

Completion of final paperwork (consents and waivers)

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What Should the Registration Team Say?

- **REGISTRATION/BEDSIDE REGISTRATION**
- Always greet patients with eye contact and a smile: "Hello, I'm <your name> and I will be completing your registration today."
- "It will take us about 5 minutes."
- "Is there anything else I can do for you?" If no, end with "If you have any questions, or need further assistance, please let any one of our team know."
- "Is there anything else I can do for you today, <Mr./Ms. patient last name>?"

- **QUICK REGISTRATION/EMERGENCY ADMISSION**
- Always greet patients with eye contact, a smile, an expression of empathy: "I'm sorry you are not feeling well," "I am sorry you are hurting" and a commitment to care: "I will get you moving in this process very quickly," "I want to get you to the doctor as soon as possible."
- Introduce yourself by name and your role: "I am Karen and I will start your registration this morning. I will be collecting just enough information for the rest of our team to begin caring for you. It will take us about 3 minutes. We will complete your registration later after you have seen your doctor or nurse."
- When completed, tell patient the next step in their care and when they can expect that step to take place.

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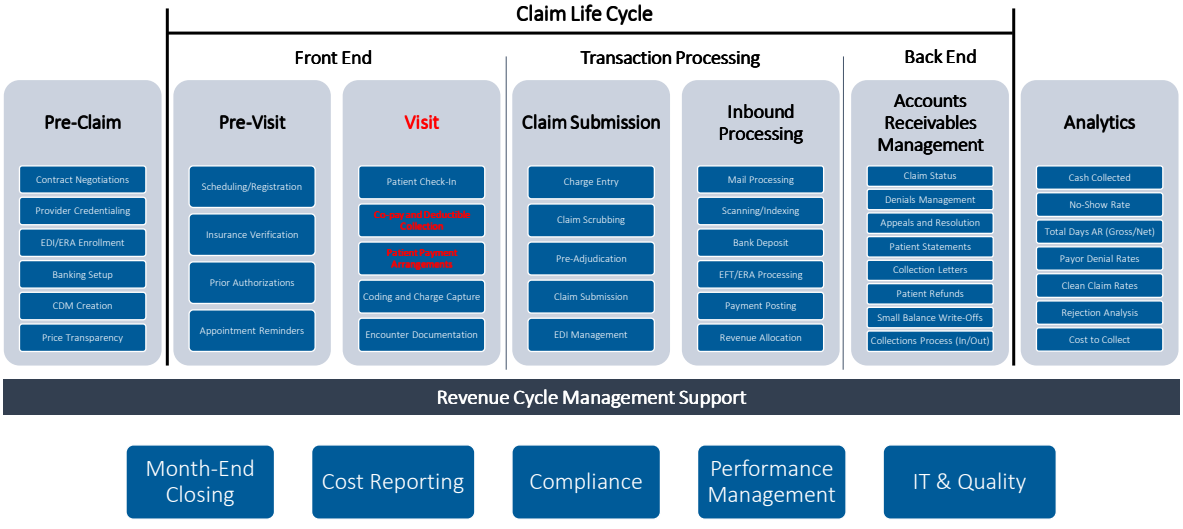
Registration – Best Practices

- Perform as much of the process prior to day of visit
- Maintain similar processes for inpatient, outpatient, emergency department and clinics with slight variations
- Emergency admissions start with a "quick registration" followed by a full registration after the patient has been medically cleared per Emergency Medical Treatment & Labor Act (EMTALA) guidelines
- Review insurance information previously obtained
- Review if authorization is required for services and confirm authorization number has been received
- Communicate potential financial responsibility to the patient
- Perform quality audits to provide feedback and coaching to patient access team

Revenue Cycle Management



Co-pay and Deductible Collection & Patient Payment Arrangements

HISTORICALLY	TODAY
• Healthcare has historically focused on collecting from insurance and third-party payors • Patient collections for deductibles and co-payments occur on the back end after claim processing • Staff members may be uncomfortable talking about money • Hospitals have 2-3 options for collecting payments from patients • Patients may not proactively seek cost and payment information	• Households are not equipped to handle a $400 emergency • Employers are offering high deductible health plans to their employees • Patients are looking for ways to pay and financing options • Providing payment options can improve the patient financial experience for patients and providers • Effective financial conversations can help patient move forward with care and avoid billing surprises

What's Happening – Surprise Billing Good Faith Estimates

Uninsured & Self Pay Provisions

Good Faith Estimates	Scheduled Estimates
Providers are required to provide estimates whenever uninsured or self-pay patients requests an estimate for care they are considering.	**Providers must provide uninsured and self-pay good faith estimates prior to all scheduled care beginning on Jan. 1, 2022.**
The patient should only receive one good faith estimate for a primary service/visit (including all convening providers).	If scheduled at least three days in advance, the provider must provide a good faith estimate regardless of whether the patient requests it.

All good faith estimates should be the cash pay or self-pay rate, reflective of any discounts available to the patient at the time!

HFMA | No Surprises: Key Considerations on Surprise Billing

Co-pay and Deductible Collection & Patient Payment Arrangements – Best Practices

Communicate potential financial responsibility to the patient prior to day of visit

Hospitals adapt to the reality that the payments will come from patient sources as high deductible health plans shift the responsibility to patients

Change the culture to understand that patient collections is a front-end activity

Train the staff on how to ask for payments and reinforce positive behaviors

Offer alternative payment options:

- Digital Payments, person to person, Health Savings Account, Healthcare Credit Cards, financing and monthly payments

Leverage Pricing Transparency and Shoppable Services

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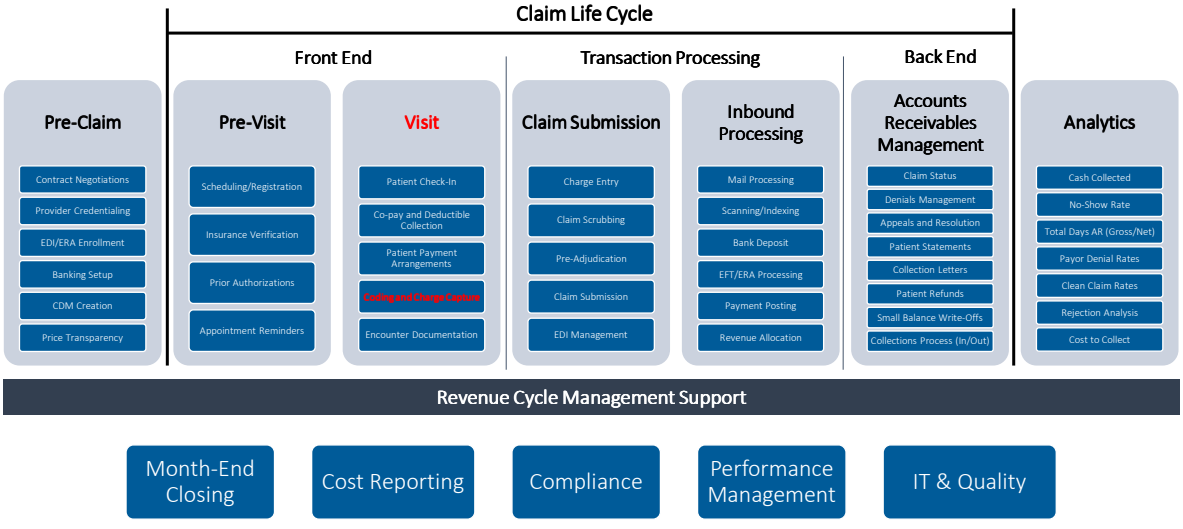


Coding vs. Billing

One Person or Multiple People

Coding

- ***ICD10***
- Transforming healthcare diagnosis, procedures, and medical services into alphanumeric codes
- Information is taken from medical record documentation

Billing

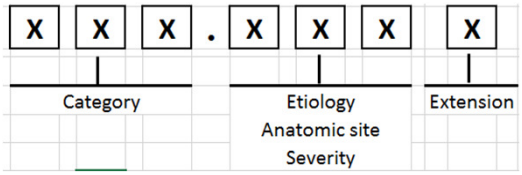
- ***HCPCS/CPT***
- Submitting claims with insurance companies to receive payment for services rendered
- Information is taken from charge codes selected by clinical staff (CDM)

What Is Coding?

ICD Diagnosis Codes

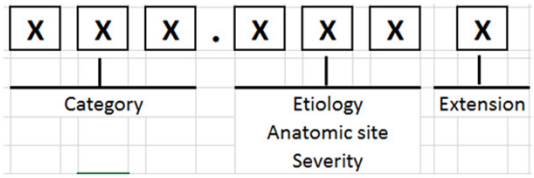
- Internationally unified codes set describing accident, illness, injuries, conditions or circumstances describing any of these. Not included in CDM.

- First 3 characters represent category
  - May ***rarely*** be a complete code
- Next 3 characters provide detail on disease, condition, location, severity etc. Extra characters may be populated with X.
- Seventh character characterizes
  - Episode of care
    - Initial
    - Subsequent
    - Sequela – visit due to complication
  - Type of fracture
  - Fracture care
  - Complication of pregnancy



7th Character (Extension)

Fracture of Shoulder and Upper Arm, Does not Require Gustilo Classifications	
A	Initial encounter for closed fracture
B	Initial encounter for open fracture
D	Subsequent encounter for fracture with routine healing
G	Subsequent encounter for fracture with delayed healing
K	Subsequent encounter for fracture with nonunion
P	Subsequent encounter for fracture with malunion
S	Sequela



Multiple Gestations	
0	not applicable or unspecified
1	fetus 1
2	fetus 2
3	fetus 3
4	fetus 4
5	fetus 5
9	other fetus

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What Is Charge Capture?

- Charges should reflect the services that were provided to the patient and supported by the clinical documentation contained within the medical record
- Timely posting of charges is usually within three to five days of service
- Charges are posted in different ways: manually, based on test results, based on documentation, etc.
- Reports available to monitor revenue and usage by department
- Charge capture is integrally connected to the chargemaster

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What Is Billing?

CODE SET	IDENTIFY	BILLING FORM	MAINTAINED BY
CPT	Procedures, services, drugs, combo services	1500 and UB-04	AMA
HCPS HZ0	Procedures, services, drugs, combo services, supplies, DME	1500 and UB-04	CMS, BCBS
Revenue Code	Location, provider, type or procedure	UB-04	NUBC
Modifiers	Add-on information to HCPCS and CPTs: location, component of service, explanation of service	1500 and UB-04	AMA, CMS
Type of Bill	4-digit code representing the place of service, type of service and billing stage. Leading number is a zero	UB-04	NUBC
Place of Service	2-digit code identifying the location of the provider, or type of service	1500	CMS, BCBS

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Coding and Charge Capture – Best Practices

- Use concurrent coding to improve medical necessity documentation
- Hold weekly nursing and HIM team meetings to discuss medical necessity documentation and charge capture opportunities
- Hold department managers responsible for monitoring revenue and usage via charge reconciliation processes
- Educate and train staff on appropriate charging and reconciliation processes
- Establish an interdisciplinary team with a goal of overseeing processes such as:
  - Conducting chart audits
  - Monitoring revenue and usage
  - Overseeing CDM issues
  - Determining billing issues related to charges
  - Reviewing managed care contracts
  - Monitoring pricing updates

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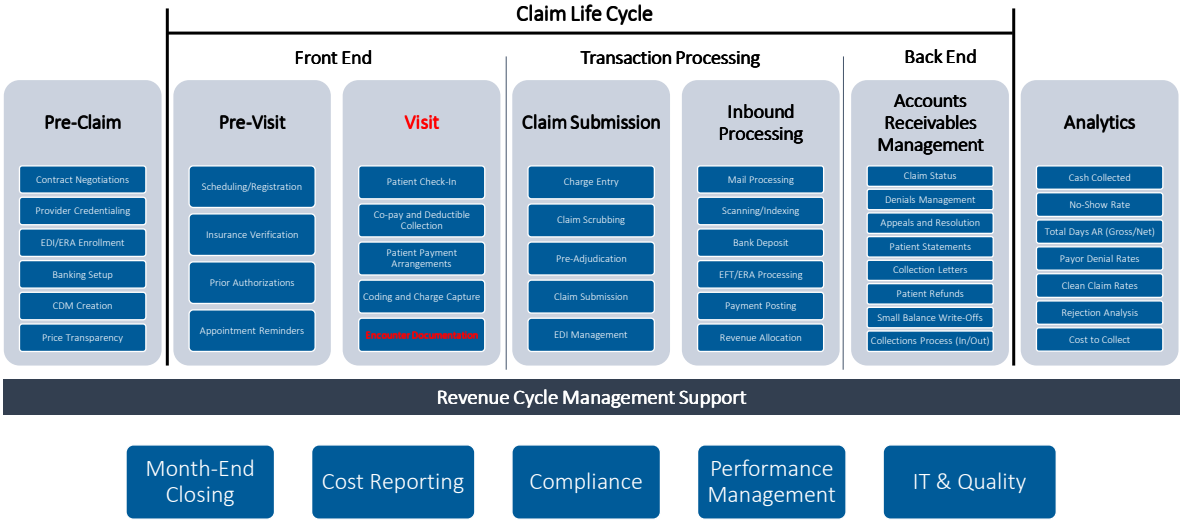
Slide 33

HZ0 Should be HCPCS?
Hillary Zipper, 2022-03-01T01:40:33.530

Coding and Charge Capture – Best Practices (cont.)

- Identify and monitor departments with charge capture issues and develop processes for improvement
- Invest in a strong charge description master (CDM) team and maintenance process
- Providing education and training to new managers regarding the charge capture process and expectations outlined in the policies and procedures
- Regular CDM management/staff meeting with departments to review reports, discuss available charges and changes related to quarterly and annual updates
- Have policies and procedures that outline the expectations of department managers regarding charge capture efforts
- Managers need to understand:
  - How to report concerns regarding charge capture issues
  - How to request a new charge code
  - Process for monitoring codes for deactivation

Revenue Cycle Management



Encounter Documentation

- Each encounter is documented through the health record for the patient
- Clinical documentation integrity (CDI) ensures health information accurately captures complete and specific provider documentation
- Hospital staff that contribute to CDI include HIM professionals, nurses, physicians
- Key skills needed for CDI professionals
  - Strong knowledge of coding guidelines and medical terminology
  - Strong ability to understand clinical indicators within the body of the health record
  - Strong written and verbal skills required to communicate and engage physicians and other healthcare providers
  - Knowledge of regulatory reimbursement methodologies and documentation requirements

Encounter Documentation – Best Practices

Develop a Clinical Documentation Integrity (CDI) program that:

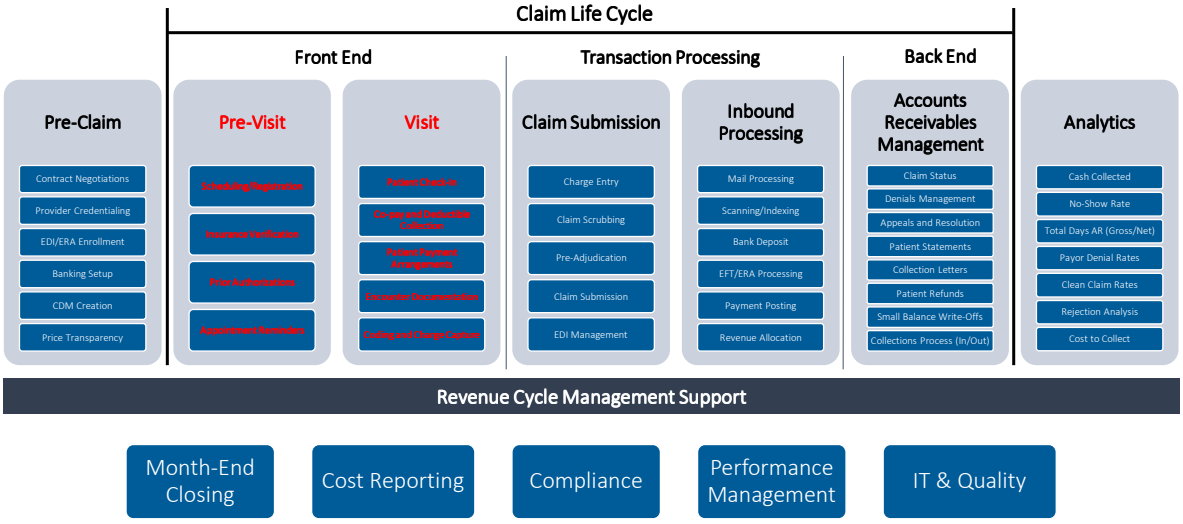
- Has a physician advisor that can champion supporting quality documentation practices
- Physician advisor engages other physicians and clinicians by addressing admission denials, Diagnosis Related Group (DRG) revisions, and other documentation discrepancies that may lead to poor quality care

Top leadership should be engaged and provide support to implement and sustain a CDI program

Monitor the following CDI Metrics

- Case mix index (CMI)
- CDI professional's review rate
- Query rate, response rate, and response time
- Quality and reimbursement impact

Revenue Cycle Management



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