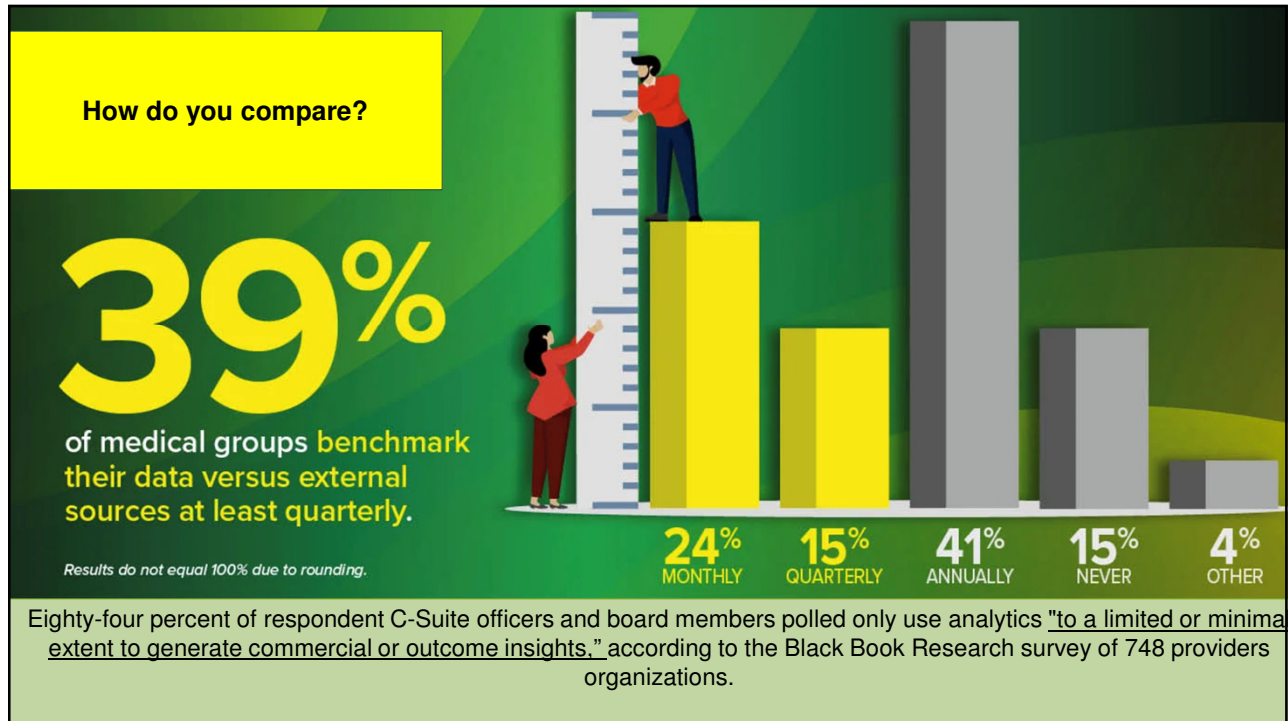


# Navigating the Revenue Cycle

A Case Study Leveraging Data to Drive Improvements

## Today's Discussion Points

- Introduction to a case study
- Defining the problem – inefficiencies in the revenue cycle
- Using KPIs as a pathway to revenue cycle solutions
- Managing by the numbers



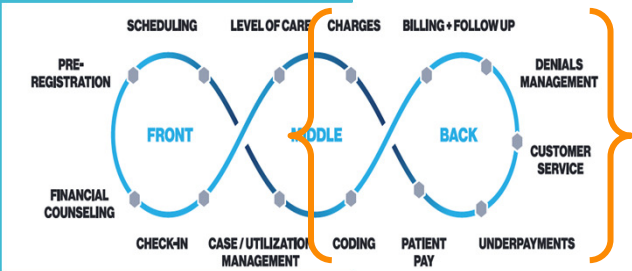
## WHAT should we benchmark?

	Reactive	Preventive	Optimize
Obtain and assess data	What is happening now in our organization?	What can we prevent from happening?	How can we get to where we want to be?
Evaluate opportunities	What does the data tell us is causing issues?	Where do we have opportunities to negate those issues?	Where do we have opportunities to streamline processes?

The selection of KPIs should align with your organization's specific goals and objectives.

# CASE STUDY

How a medical practice used KPIs to improve financial performance



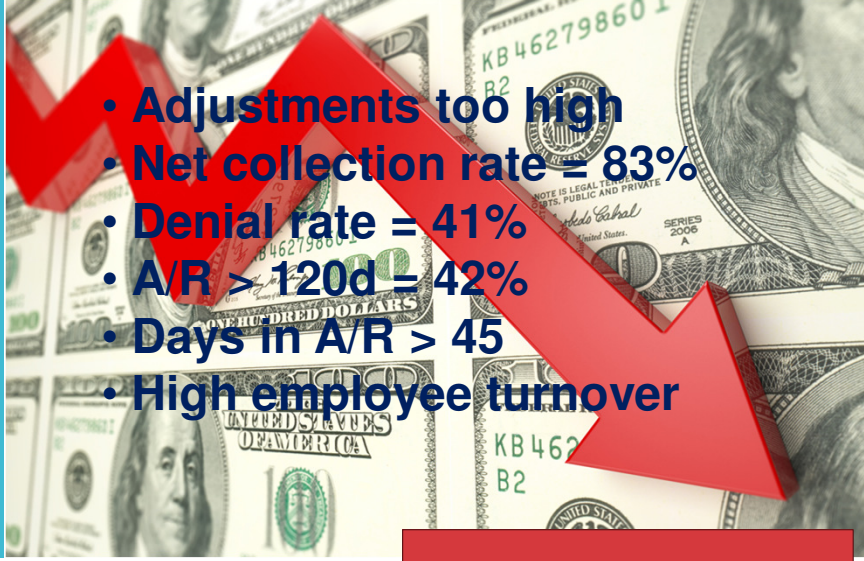
Identifying the issues

Understanding the process

Overcoming the challenges using KPIs

Benchmarking against best practices

Identifying the problem



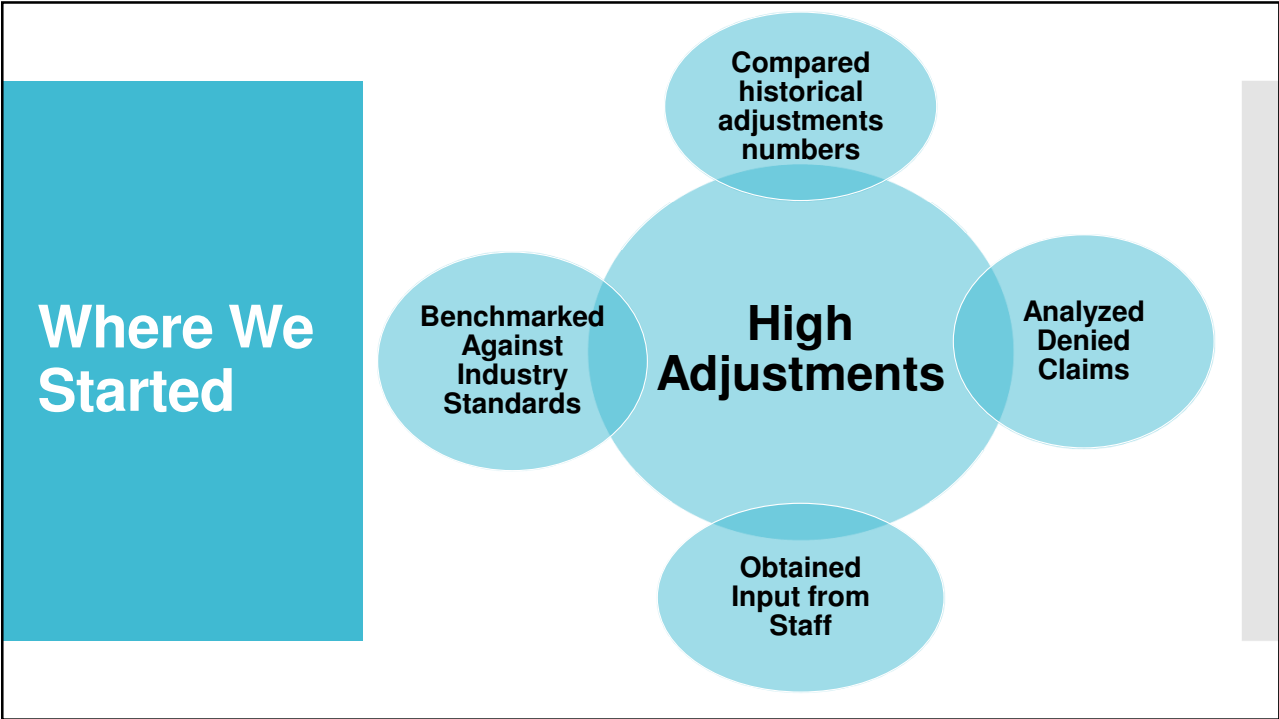
- Adjustments too high
- Net collection rate = 83%
- Denial rate = 41%
- A/R > 120d = 42%
- Days in A/R > 45
- High employee turnover

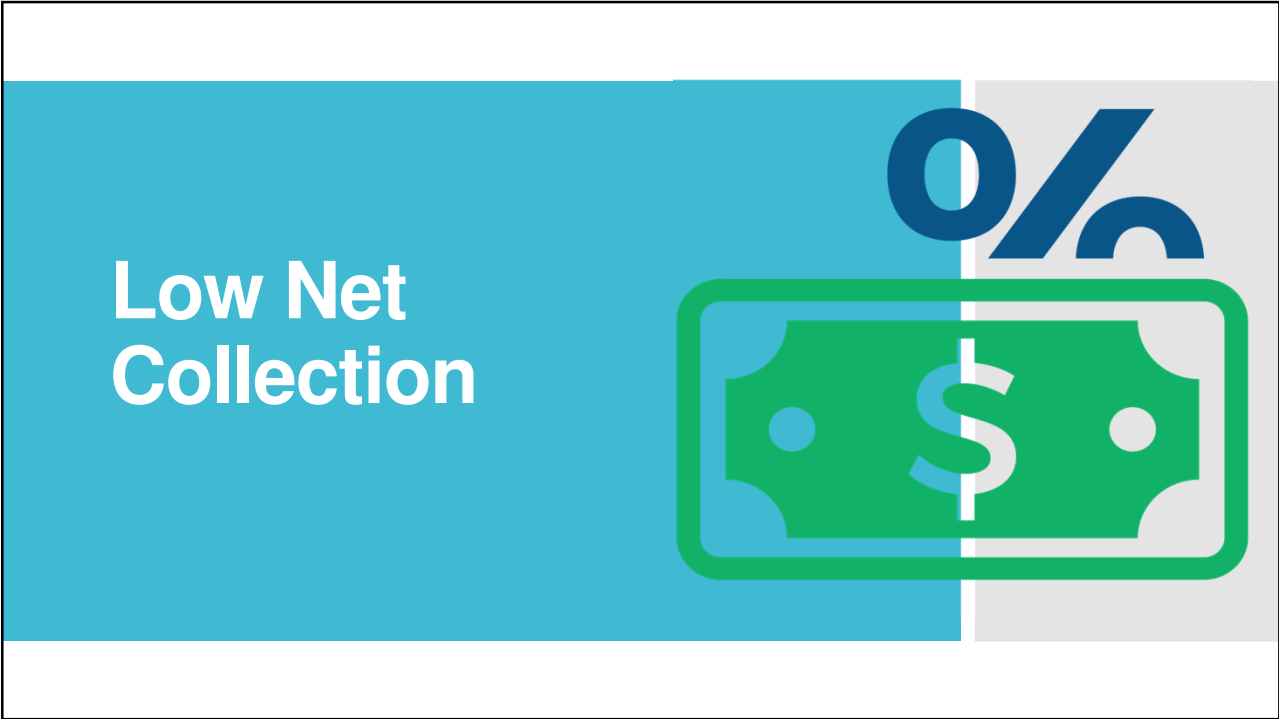
Negative bottom line

# Adjustments

## Top 12 Reasons for Medical Claim Denials

- #1 - Duplicate Claims
- #2 - Typos
- #3 - Deductible
- #4 - Health Plan Benefits Exceeded
- #5 - Insufficient Information
- #6 - Problem with Modifiers
- #7 - Site of Service Problem
- #8 - Coding Mix Up
- #9 - Outdated Codes
- #10 - Service Not Covered
- #11 - Lack of Medical Necessity
- #12 - Out of Network





**ISSUE:**  
**Low Net Collection %**

*Actual %*  
**83%**

*Target Benchmark %*  
**95%**

*How to calculate –*  
 $(\text{Payments}/(\text{Charges}-\text{Contractual Adjustments}) * 100\%$

**The ISSUES**

- Non-credentialed provider write-offs
- Coding errors
  - Modifiers
  - ICD-10 excluded pairs
  - Payer regulations related to CPT codes

**Best Practice Tips**

Collection Rate - 95% to 99%

Maximum 99% Average 95%

The highest performers achieve 99%. Average adjustment rate should be 95%.

A complex block containing text, percentages, a list of issues, and best practice tips. It includes a diagram showing an 83% actual collection rate and a 95% target benchmark rate, with a yellow arrow pointing from the actual to the target. The issues listed are non-credentialed provider write-offs and coding errors (modifiers, ICD-10 excluded pairs, payer regulations). Best practice tips include a collection rate target of 95% to 99%, with a note that the highest performers achieve 99% and the average adjustment rate should be 95%.

## SOLUTION:

### Low Net Collection %

*% After Focus*  
**94.8%**

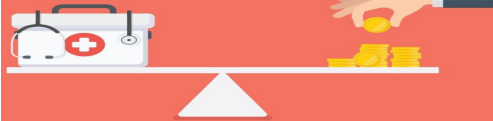
- Created a provider credentialing tracking spreadsheet
- Began the credentialing process earlier and scheduled only patients until providers were fully credentialed
- Trained the RCM employee (coding, regulations, critical thinking)
- Provided consistent feedback and education to the providers

Contractual    Non-contractual



Categorizing your non-contractual and contractual adjustments will reveal the source of error and give you an opportunity to make amends.

Stay aware of the fee schedules and reimbursements schedules.



## Claim Denials

**5%**

of net patient revenue:  
Loss through unresolved denials

**20%**

Rise in denial rates  
in the past five years

**60%**

Percentage of declined  
claims which are never  
re-submitted

**\$180+**

Cost per claim to hospitals  
for rework or appeal




**ISSUE:**  
Denial Rate %

Actual %: 41%  
Target Benchmark %: 5%

*How to calculate –*  
Total # of claims denied/ Total # of claims submitted (for a specific period).

Top-performing organizations are getting claims paid in 20 days or less.

Claims paid on first submission save you money, time, and resources spent on costly re-work and appeals.

	+		=	
<b>\$6.50</b> The average cost to file a claim*		<b>\$25–\$118</b> The cost to resubmit a denied claim (cost varies for professional and institutional claims)*		<b>\$31.50–\$124.50</b> The total cost to submit, correct, and resubmit a claim*

**SOLUTION:**  
Denial Rate %

- Developed a more effective way of viewing and correcting denied claims (by type)
- Trained on payer-specific requirements
- Updated CPT and ICD-10 coding resources
- Identify payers with the largest number of denials and reasons

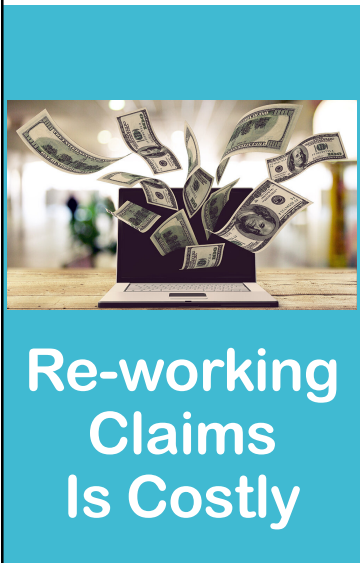
**% After Focus**  
15%

Top 3 Reasons for Denial Increases

Insufficient data analytics	62%
Lack of automation in claims/denials process	61%
Lack of thorough training	46%

SOURCE: Experian Health 2022





## Re-working Claims Is Costly

### 1 How Much Reimbursement Are You Losing to Denied Claims?

Fill in number of claim denials  **Your Revenue Loss Adds Up to:**

Per week

Per month

Per year

Fill in average reimbursement dollar amount per claim

### 2 Calculate What Reworking Claims Is Costing You

Fill in number of denied claims per physician per year  **Attempting to Rework Claims for Reimbursement Costs Your Practice:**

Per week

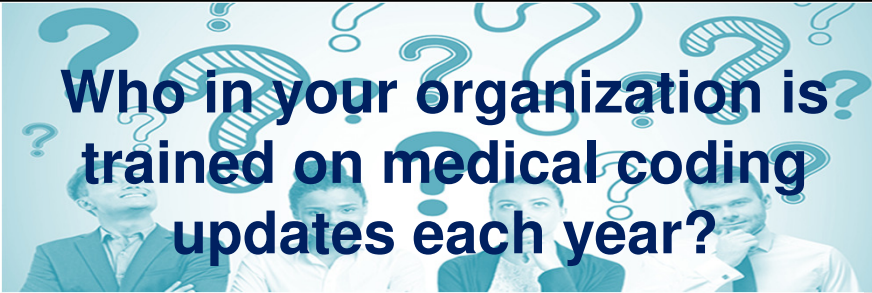
Per month

Per year

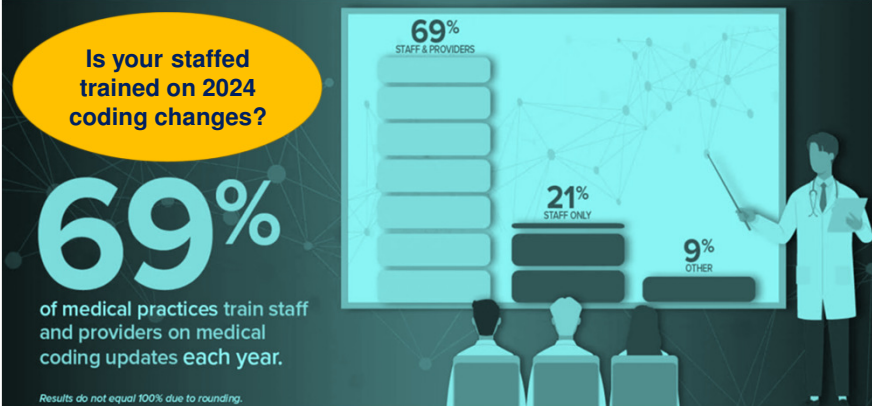
Average cost to rework a single claim\*

Number of physicians in your practice

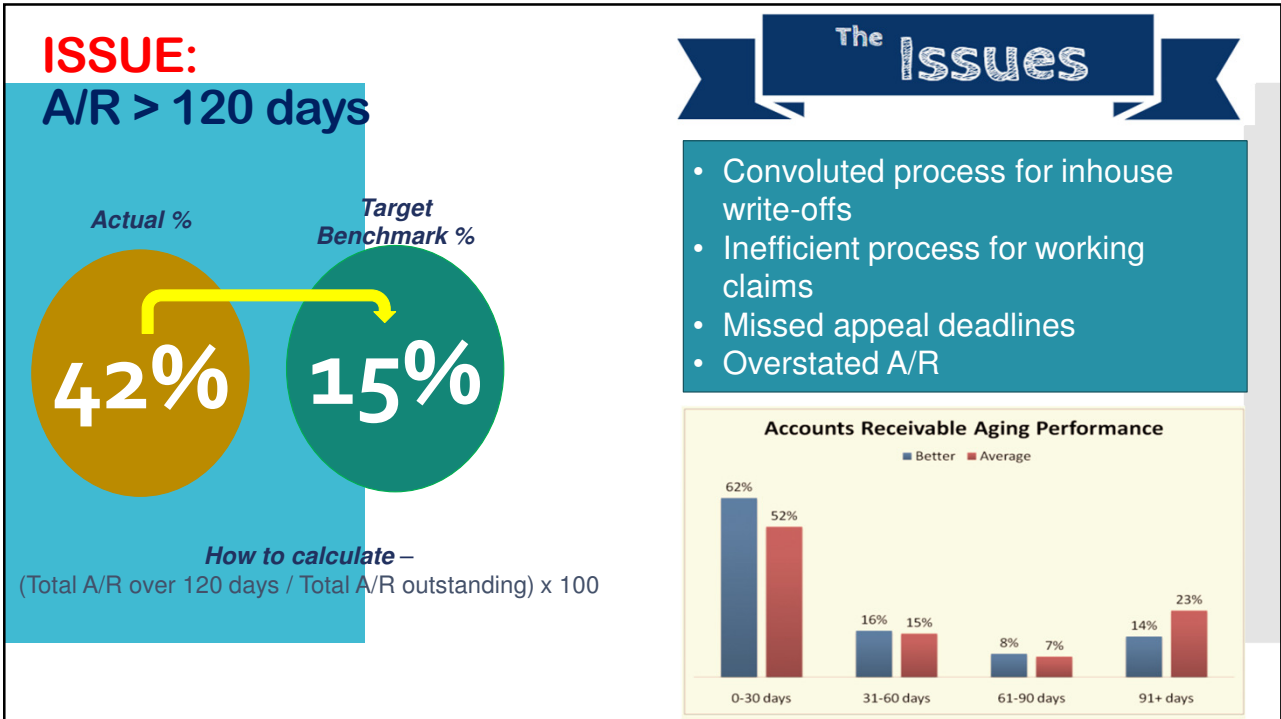
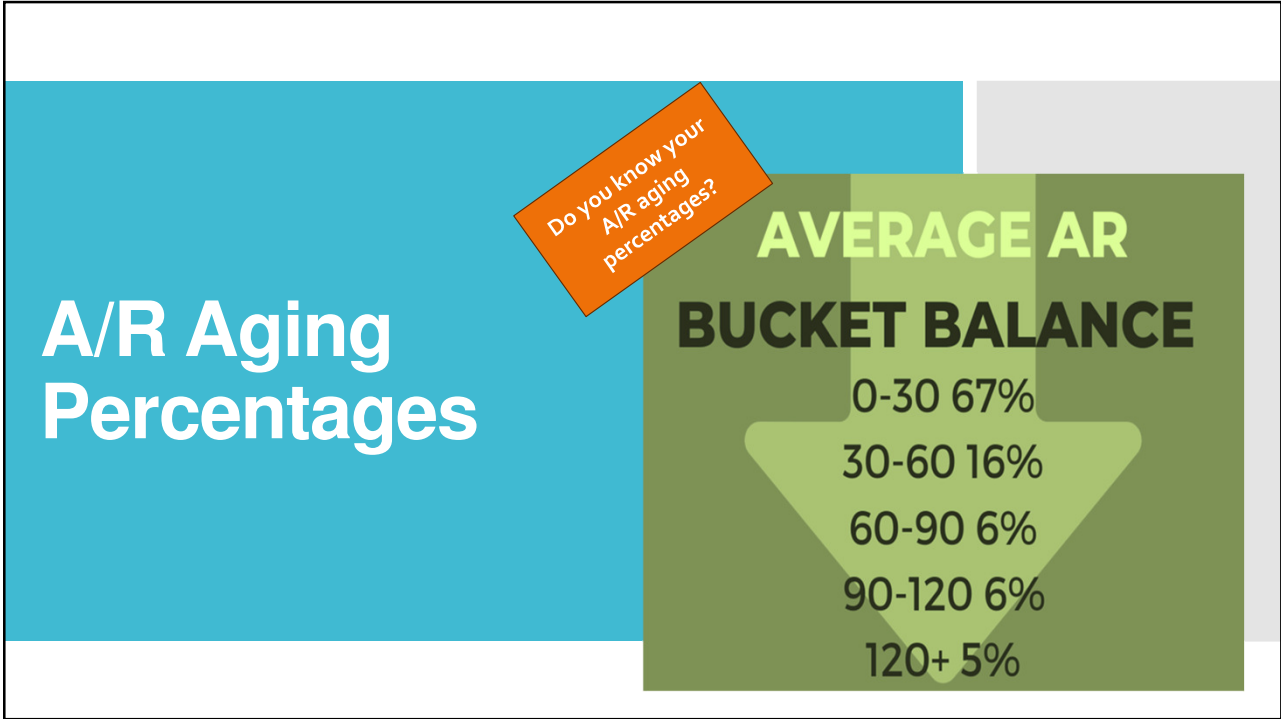
## Education Prevents Denials



Who in your organization is trained on medical coding updates each year?







### SOLUTION:

#### A/R > 120 days

- Focused attention on A/R aging
- Corrected denials and resubmitted within deadlines
- Reviewed patient balances and referred to bad debt as appropriate
- Cleaned up accounts with denials that were uncollectable and could not be sent to patient responsibility
- Redefined process for write-offs

#### Watch Report

% After Focus  
**<13%**

One way to run the report to make the insurance AR “look better” is to run the report based on date-of-last insurance submission.

## Days in A/R

State of your DAR – increased, stayed the same or decreased??


# 56%

of medical groups say their time in A/R increased in 2022.



### ISSUE:

## Days in A/R



**AR DAYS - WHAT THIS NUMBER MEANS FOR THE HEALTH OF YOUR PRACTICE**

**Actual %** 45      **Target Benchmark %** 35

*How to calculate* –  
Total Account Receivable/ (12 months of gross charges/365)


- < 35 - Excellent
- 35 – 50 - Average
- > 50 - Poor

### SOLUTION:

## Days in A/R

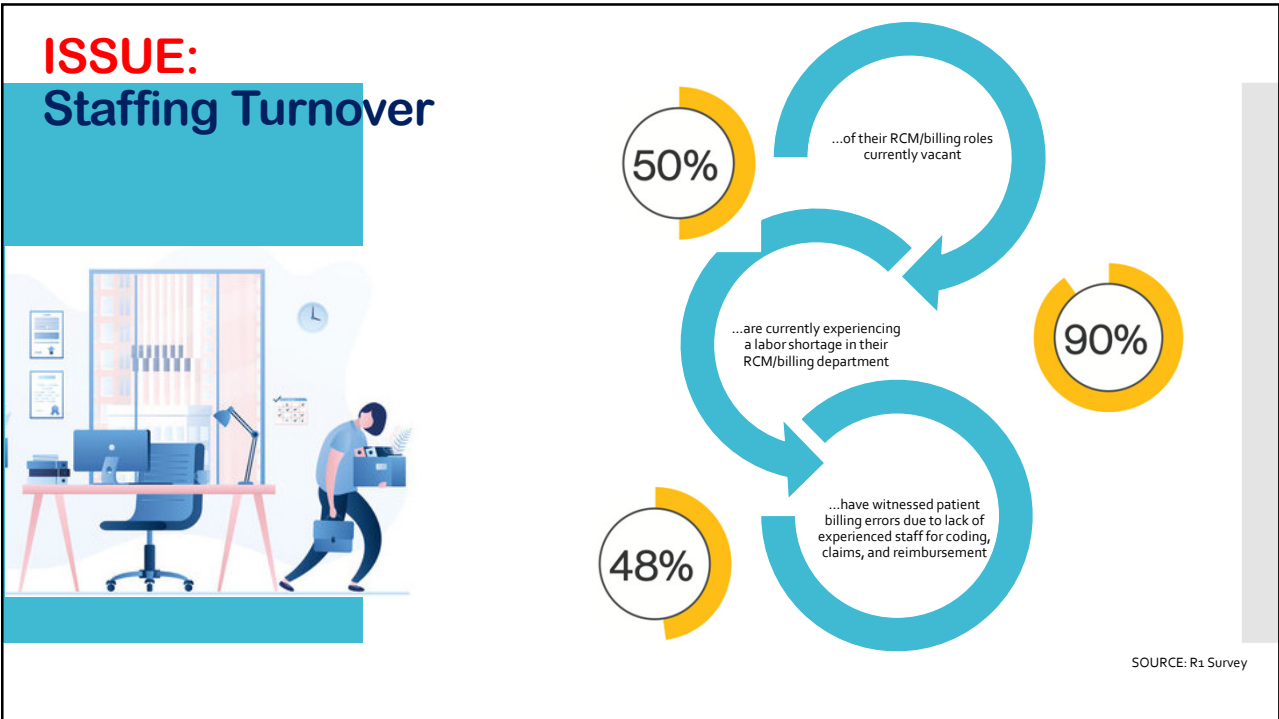
- Utilized a “claim scrubbing” tool to catch clerical and coding errors
- Consistently reviewed monthly A/R reports
- Worked all denials immediately
- Corrected processes and provided education regarding coding errors
- Communicated frequently with patients with outstanding balances

**Timely payments are essential for effective operations.**



**63      35      27      22**

**33%** % After Focus



## SOLUTION: Staffing Turnover

**Numbers**


- Understand the turnover rate
- Conduct an exit interview

**Training**

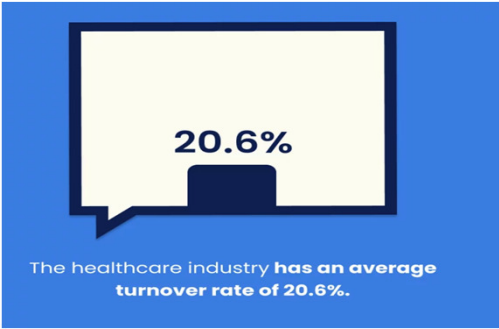
- Foster a team mentality
- Crosstrain employees

**Due Diligence**

- Hire the right employees
- Do a better job at keeping employees



**33%**  
In the United States, **33% of new hires leave their job** within the first 6 months.



**20.6%**  
The healthcare industry has an average turnover rate of **20.6%**.

**Goal: 15%**

## A METRIC THAT MATTERS employee turnover

### Impacts of Understaffing

Employee burnout/ Staff dissatisfaction	76%
Higher staff turnover	48%
Decreased reimbursement/ Slower claims processing/ Increased claims denials	48%
Lowered data quality	37%
Slower release of information	36%
Slowed implementation of regulatory requirements	19%
Privacy errors/ Decreased patient privacy protections	14%
Decreased patient safety	7%
None	6%

Professionals in revenue cycle management are responsible for critical processes that help ensure the flow of 4.07 billion electronic claims per year.

Source: 2022 CAQH Index - CAQH, 2023

**QUESTION:** What consequences of understaffing among HI positions have you seen impact your organization within the last year? Select all that apply. (N=1645)  
**NOTE:** Respondents were able to select multiple response options, so totals do not equal 100%


**“Perfection is not attainable, but if we chase perfection we can catch excellence.”**

**-Vince Lombardi**

*YOU NEED TO DO SOMETHING ABOUT THIS*

- Measuring and benchmarking is an activity performed in vain if something isn't done with the findings.
- Results should be used to support change and create operational improvements.

**Leverage data as a competitive advantage.**



**Value and Measurement**      **If you don't measure it, you can't manage it.**      **If you don't value it, you won't change it.**

**Using Key Performance Indicators (KPIs) to Benchmark**

**“To manage something, it is necessary to know what it is, where it is in relation to other things, and describe how it got there.”**

**-Feltenberger/Gans**





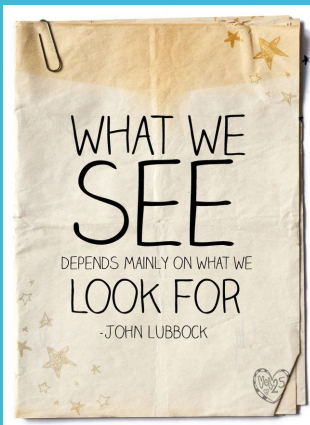
Using KPIs, the case study demonstrated:

- Inefficiencies in the revenue cycle
- A pathway to revenue cycle solutions
- How to effectively manage by the numbers

KPI	BEFORE	AFTER
Net Collection Rate	83%	94.8%
Days in A/R	45	32.9
Denial Rate	41%	15%
A/R > 120d	42%	13%
Employee Turnover		<i>In progress</i>

### MANAGING BY THE NUMBERS

Consistently use KPIs to identify new processes to attain superior performance.



# THANK YOU



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