Revenue Cycle

PERFORMANCE GUIDE

c|h|a
Colorado Hospital Association

Contents

Target audience: Patient financial services managers, patient access managers, health information management managers, performance improvement specialists, chief operating officers, chief financial officers, and chief executive officers.

Goal: Organizations will improve revenue cycle performance by examining current processes, reviewing internal revenue cycle measures compared to benchmark standards, and identifying areas of opportunity.

Purpose: Organizations will use this guide to drive awareness and understanding of resources and industry standard processes, initiate yearly performance improvement projects related to revenue cycle performance, implement new processes to improve days in accounts receivable, and create a culture of revenue cycle excellence.

Introduction

The revenue cycle is made up of multiple processes to ensure a clean claim is submitted to payers for timely payment. These processes can begin before a patient arrives at the hospital and continue weeks to months after a patient leaves the hospital. Breaking down each revenue cycle process (**FIGURE 1: REVENUE CYCLE LIFE CYCLE**) and measuring performance will lead to better financial outcomes. It is important to note that while revenue cycle processes are not all patient-facing processes, they will all impact patient perception of care, patient satisfaction, and are a deciding factor on where patients in the community seek care.

Four challenge areas that impact revenue cycle processes, hospital vitality, and ultimately patient experiences are outlined throughout this document. These four challenge areas can be used as starting points for hospital leaders to identify areas of opportunity and build out actionable next steps for improvement.

Key Resources:

National Rural Health Resource Center

- *Small Rural Hospital and Clinic Finance 101 Manual*

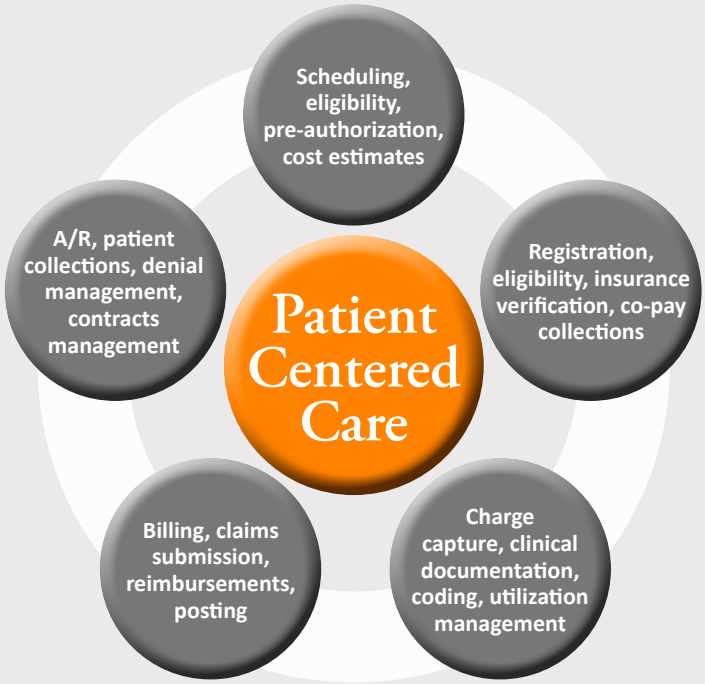
Institute for Healthcare Improvement

- *Plan-Do-Study Act (PDSA) Worksheet*
- *Run Chart Tool*

Partners

- *Western Healthcare Alliance (WHA)*
- *Healthcare Management (HCM)*

FIGURE 1: Revenue Cycle Life Cycle



Commonly Used Terms

- **Aged trial balance (ATB) report:** A report commonly built into the hospital electronic medical record that can be automated.
- **Advanced beneficiary notice (ABN):** Notices given to Medicare beneficiaries to notify them that a specific service may not be covered by insurance.
- **Bad debt:** An expense that a hospital or business incurs that is estimated to be uncollectable.
- **Clean claim rate:** The rate at which insurance claims have passed all edits without manual intervention and have been successfully accepted by payers.
- **Credit balances:** An amount that will need to be researched and possibly refunded to a patient or insurance company.
- **Current procedural terminology (CPT) code:** A uniform code used to identify and report medical services and procedures.
- **Days in accounts receivable (A/R Days):** A formula that indicates how long it takes to receive payment and clear accounts receivable.
- **Days in accounts receivable greater than 90 days (A/R Days >90):** An amount that indicates the accounts and dollars that are greater than 90 days.
- **Discharged and no final bill (DNFB):** Accounts that remain incomplete due to coding or documentation gaps.
- **Discharged and no final charges (DNFC):** Accounts that are waiting on charge completion.
- **Financial assistance:** Discounted medical care provided after patients are approved for assistance.

Days in Accounts Receivable

Hospitals focus on days in accounts receivable (A/R Days) and days in accounts receivable greater than 90 days (A/R >90 Days) because these metrics directly impact the hospitals operating margin, and with ever-changing payment structures, this is a key measure for vitality of a rural hospital. Western Healthcare Alliance (WHA) and Healthcare Management (HCM) have the resources to assist rural hospitals with key metrics and aligning to industry standards.

The first step in identifying how a hospital compares to benchmark standards is to review financial reports with hospital leaders to determine if standards are being met, need improvement, or are significantly below industry standard.

(Note that benchmark rates will vary depending on different organizational standards.)

Step 1:

Run an aged trial balance report (ATB). This report should be built into the hospital electronic medical record and can be automated.

Step 2:

Analyze and trend by payer with oldest aging dates.

Step 3:

Review the analysis.

3.1: If the analysis shows commercial payers are outstanding:

1. Pull contractual data for payers.
   a. If claims are out of timely filing, an action plan will be needed for possible write-offs. An action plan is needed to prevent future timely filing denials.
      i. Before write-offs, determine what caused the timely filing denial (e.g., coding, insurance information added late, etc.).
   b. If claims are still within the timely filing limit, status online and rebill as needed.
      i. Before rebilling a claim, determine why the claim was not accepted previously and document the reason (e.g., incorrect payer ID, audit trail rejection, etc.).

3.2: If the analysis shows government payers are outstanding:

1. Identify your highly skilled accounts receivable representatives to run a report and prioritize claims by aged date, then rebill as needed.
   a. Do not rebill until it has been determined why the claim was not accepted previously. If a claim was billed paper, it is recommended to send certified mail.

Additional financial reports to review that will help in reducing A/R Days include bad debt, financial assistance, discharged and no final bill (DNFB), discharged and no final charges (DNFC), accounts waiting for coding, clean claim rate, and credit balances. Reference the revenue cycle score cards for benchmarking.

Front-end Revenue Cycle Collections

Prior to a patient arriving at a hospital, there are key steps to ensure a successful financial experience for both the patient and the revenue cycle personnel. Front-end revenue cycle processes ensure that patient information is correctly documented during encounters and when starting a financial account for the patient. By taking proactive steps to ensure information is collected properly, the time spent on registering patients will be reduced, patients will be aware of financial responsibilities, and financial key performance indicators will improve.

Central scheduling has a major role in improving overall efficiencies within the patient access arena and in increasing patient satisfaction. When contacting a patient to verify demographics and discuss possible amounts owed due to the patient's health plan, ensure the patient understands patient responsibilities in the billing process. This allows the patient to plan financially, and if necessary, discuss additional options with the treatment provider or ensure that the selected treatment option is coded correctly.

Pre-registration and pre-authorization processes are often incorporated into the function of central scheduling. Hospitals can begin by identifying which services would be best suited for central scheduling to assist with (e.g., radiology) and which services are best suited for the department to maintain (e.g., surgery). Pre-authorizations assist the hospital overall, as they increase the number of claims being paid correctly and on time, and they proactively support coordination with clinical staff and utilization management.

Pre-registration Goals:

1. **Contact the patient to:**
   a. Ensure demographics are current and complete; verify and update as needed.
   b. Document insurance and/or third-party liability information for every encounter.
   c. Discuss potential financial responsibilities of the patient:
      i. Discuss applying for financial assistance or repayment plan options.
      ii. Ensure that financial assistance program and repayment plan policies are in place and appropriate staff members are trained to collect additional information (e.g., tax returns, copies of bills, etc.).
   d. Advise the patient on what to expect when arriving at the facility on the day of the appointment, including the need to verify insurance at registration.
   e. Explain when copay and deductible amounts are determined.
   f. Answer additional patient questions or concerns as needed.

Successfully incorporating front-end revenue cycle collections and pre-registration processes will lead to improvement with point-of-service collection, insurance payments, and patient satisfaction measures.

Clinical Involvement with Revenue Cycle

Engagement with clinical staff is best practice, and leadership representatives for clinical areas should be included on the revenue cycle performance improvement team (e.g., chief nursing officer, nursing director, chief clinical officer, etc.). Clinical representation will inform revenue cycle leadership on clinical workflow processes that may be impacting key metrics and support improvement in these areas.

One specific area that can be improved with help from clinical representation and hospital leadership is the Advanced Beneficiary Notice (ABN) process. ABNs are notices given to Medicare beneficiaries to notify them that a specific service may not be covered by insurance. This is often due to the coding of the service or diagnosis. Because of this, patient financial services and patient access leadership should monitor ABN notices and involve clinical representation and hospital leadership to identify next steps in resolving or reducing the number of ABNs. ABNs are completed at the time of registration and saved to a patient's medical chart. *If this process is not completed correctly*, the hospital is responsible for writing off the charge of service. Leadership must increase education with physician and clinical teams regarding the importance of correct diagnosis for testing and how much revenue is lost due to incorrect information.

Clinical representatives should also be informed on all revenue cycle processes, with an emphasis on understanding the importance of correct and timely charge entry and quick responses to coding and documentation questions. For example, it is recommended that charges be entered within 24 hours of the service. Education about how revenue cycle processes are impacted when information is incorrect is an opportunity and should have a clinical champion and a leadership sponsor.

Reference the Centers for Medicare and Medicaid Services (CMS) website for specific and up-to-date guidance on completing ABNs. Completion of the ABN should include the non-covered current procedural terminology (CPT) code, description, and charge amount. The patient must check one of the boxes on how they wish to proceed, sign, and date the document. If any of this information is incomplete, the ABN is not valid.

Prioritization of Billing and Payer Follow Up

After the revenue cycle score cards have been completed and reviewed by the revenue cycle performance improvement team, prioritization of billing and payer follow up should begin as soon as possible. Prioritizing billing and payer follow up will result in improvement across multiple metrics. New processes will need to be clearly communicated to patient financial services and health information management staff. It is also recommended that a lead is identified in each department to help support leadership in ensuring progress is made and to help with identifying and resolving workflow issues.

Billing Prioritization:

1. **Address large dollar claims first.**
   a. The patient financial services team can identify large dollar claims.
2. **Address claims that have timely filing restrictions next.**
   a. The health information management team can identify uncoded accounts.

Payer Follow Up:

1. **Claim status for government claims should begin at 35 days.**
   a. Medicare pays a clean claim in 14 days.
2. **Claim status for commercial claims should begin at 45 days.**
   a. Reference contracts with payers to determine timely filing requirements.

All denials should have a unique write-off code so reports can be easily pulled to identify what types of denials are being received and the percentage of denials compared against the total number of claims. Denials should be tracked and discussed with the revenue cycle performance improvement team when meeting to determine root causes and what can be done to prevent denials in the future. The cost of denials makes up an estimated 20 percent of revenue expenses.

Example Denial Categories:

- **Medical necessity/level of care**
- **Eligibility**
- **Authorization**
- **Timely filing**

2021 Revenue Cycle Score Cards

Revenue Cycle Indicator Legend

This section is based on performance benchmark rates monitored by WHA and HCM for their members.

INDICATOR	GREEN	YELLOW	RED
Bad debt	<3%	3.1%-4%	>4%
Charity	3%-4%	2%-3%	<2%
DNFB	<4	5-8	8+
% of accounts over 60 days in waiting for coding	<5%	5%-7%	>7%
A/R >90 Days	<19%	19%-25%	>25%
A/R Days (gross)	<45	45-55	>55

Revenue Cycle Indicator Dashboard

This section should be monitored and tracked by the revenue cycle performance improvement team to identify areas of opportunity and areas of success.

INDICATOR	GREEN	YELLOW	RED
Bad debt			
Charity			
DNFB			
% of accounts over 60 days in waiting for coding			
A/R >90 Days			
A/R Days (gross)			

Health Information Management Indicator Legend

This section is based on performance benchmark rates monitored by WHA and HCM for their members.

INDICATOR	GREEN	YELLOW	RED
DNFB	<4	5-8	>8+
DNFC	<3	3.1-5	>5
% of accounts over 60 days in waiting for coding	<5%	5%-7%	>7%

2021 Revenue Cycle Score Cards cont.

Health Information Management Indicator Dashboard

This section should be filled out and monitored by health information management leadership and reported to the revenue cycle performance improvement team.

INDICATOR	GREEN	YELLOW	RED
DNFB			
DNFC			
% of accounts over 60 days in waiting for coding			

Patient Financial Services Indicator Legend

This section is based on performance benchmark rates monitored by WHA and HCM for their members.

INDICATOR	GREEN	YELLOW	RED
A/R Days (gross)	<45	45-55	>55
A/R >90 Days	<19%	20%-25%	>25%
Clean claim rate	>98%	97%-90%	<90%
Credit balances (of aging; gross revenue)	<2 days	3-4 days	>4 days

Patient Financial Services Indicator Dashboard

This section should be filled out and monitored by patient financial services leadership and reported to revenue cycle performance improvement team.

INDICATOR	GREEN	YELLOW	RED
A/R Days (gross)			
A/R >90 Days			
Clean claim rate			
Credit balances (of aging; gross revenue)			

Example: Revenue Cycle Indicator Dashboard

INDICATOR	GREEN	YELLOW	RED
Bad debt		3.5%	
Charity	3%		
DNFB	3		
% of accounts over 60 days in waiting for coding		5%	
A/R >90 Days		22%	
A/R Days (gross)	40		

About WHA, HCM, and CHA

About Western Healthcare Alliance:

Western Healthcare Alliance (WHA) began in 1989 when a small group of rural Colorado hospitals decided that there was power in numbers. Today, WHA celebrates over 30 years of collaboration with 32 health care members in Colorado and Utah. In 2015, WHA formed the Community Care Alliance to provide a population health infrastructure for rural hospital and provider communities to learn and succeed in the new health care environment. Developing and managing a menu of member-owned and partner programs, WHA saves members money that helps them remain sustainable and viable in their communities. Learn more at www.wha1.org.

About Healthcare Management:

Healthcare Management (HCM) is proudly owned and managed by 21 rural hospitals and health care organizations who are also members of WHA. HCM provides revenue cycle services for rural and community hospitals, large health systems, physician groups, skilled nursing facilities, and more through its companies A-1 Collection Agency and AR Services. Please contact Jo Ellen Hill if you have any questions. She can be reached at 970.986.3600 and at Joellen.Hill@arservices.org.

About Colorado Hospital Association:

Colorado Hospital Association (CHA) is a leading voice of the Colorado hospital and health system community. Representing more than 100 hospitals and health systems throughout the state, CHA serves as a trusted, credible, and reliable resource on health issues, hospital data and trends, media, policymakers, and the public. Through CHA, Colorado's hospitals and health systems work together in their shared commitment to improving health and health care in Colorado. Learn more at www.cha.com.

About Colorado Center for the Advancement of Patient Safety:

As a grant-funded subsidiary of CHA, the Colorado Center for the Advancement of Patient Safety (CCAPS) has supported clinical quality programs for the Association's members since 2007. The CCAPS team is composed of clinicians, quality professionals, clinical managers, project managers, and data analysists, many with direct experience working in hospitals. CCAPS provides support for pay-for-performance programs and works closely with the Association's rural health and hospitals department, led by Benjamin Anderson, who can be reached at 720.330.6011 and at Benjamin.Anderson@cha.com.