Critical Components of Effective Revenue Cycle Management

Presented to

Michigan Alliance of Healthcare Access Professionals

February 18, 2011

Presented by

Bruce Nelson

Executive Director, Business Development

(262) 510-8000

bnelson@convergentahc.com

www.ConvergentAHC.com

Confidential & Proprietary

Agenda

- Overview of Today's Environment
- Front End Processes
- Collections and Vendors
- Michigan Laws
- Questions

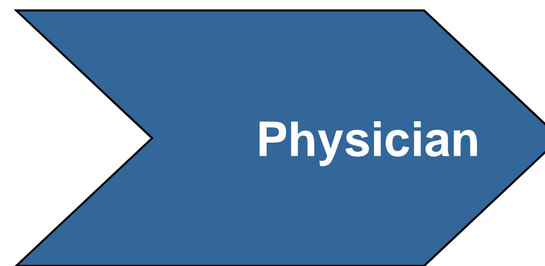
Challenges

- Multiple scheduling departments and systems
- Various Pre-Access processes
- Inconsistent information
- Billing errors are more likely
- Pre-certification/insurance verification services sporadic
- POS collection low and bad debts high
- Number of patients pre-registered is low
- High number of patient walk-ins
- High number of patients scheduled within 24-48 hours of service
- No-show rate high
- Multiple patient access points
- Patient admittance time too lengthy
- Patient and physician satisfaction low
- Clinical versus a financial-based culture

The Process with Stakeholders

The process is a physician, patient and hospital focused approach that manages the patient experience from the time the service is scheduled to when the patient arrives at the facility.

•Timely scheduling of the service
•Pre-registration of the patient
•Expanded business hours
•Way finding
•IVR reminding/collections
•One call/one department service
•Expedited patient registration
•Improved physician and patient satisfaction
•Improved pre service patient communication



•Patient Advocacy
•Dedicated Physician Liaison
•Expanded Business Hours
•One call process
•One to two service ordering process
•Specialty service units
•Improved Physician Satisfaction

•Dedicated Clinical Department Liaison
•Less cancelled or no show services
•Increase in gross revenue
•Improved financial performance
•Improved data accuracy
•Improved patient satisfaction

Comprehensive Cost-Effective Approach

Access

- Physician electronic ordering of service
- Medical Necessity screening
- Scheduling with in 48-72 hours of receipt of order
- Pre-registration
- Pre-certification, Insurance Verified, Out of Pocket amount computed

Financial

- Credit Scoring
- Ability to pay determined
- Third Party/Patient Funding
- Financial Clearance

Collections

- Expedited Registration
- Monies Collected if Necessary
- Effective Collection Follow Up
- Knowledge of State and Federal Laws

Front End Processes

- Successful outcomes used to measure the revenue cycle management process has roots in the front-end processes

- Setting targets is a balance between the current status of performance and best practice standards:

  * Improved data quality
  * Increased net revenue
  * Improved productivity and performance
  * Increased cash collections
  * Reduced need to rework accounts back end due to errors

Pre Access Dash Board

Metric	Benchmark	Your Facility
Scheduling rate of all potential patients; non emergent	100%	
Pre-registration rate of scheduled patients	95%	
Insurance verification rate of scheduled patients	95%	
Pre-certification rate of potential accounts	100%	
Request rate of out of pocket monies	95%	
Data quality	98%	
Average Registration through put time	10 minutes	
Average Registration wait time	10 minutes	
Abandoned call percentage	2%	
Average call hold time	2 minutes	
First pass yield	98%	
POS Collections as a percent of total potential	80%	

Scheduling

- Train with scripting, to ensure more efficient dialogues with patients and/or physician offices.
- Complete patient demographic data, correct procedure codes and all financial and payer data
- Education and systems, such as improving patient access staff education on clinical procedures
- Expanded telephone system to effectively route calls and assure excellent customer access to scheduling staff

Pre-Registration

- Standards that assure completing the data set as quickly as possible after the service scheduling and/ or admissions
- Preregistrations completed within three days of scheduling a service or within three days of receiving notification of an admission
- Establish minimum data set that encompasses all the data elements required to generate a "clean claim."
- Rely upon registration data in the patient record to submit a claim without requiring additional rework

Registration

- Quality of data collection for every patient encounter, as one cannot assume patient demographic and insurance data is correct from one visit to the next.
- Best practice also includes scripted training on collecting patient-pay balances for patients who may have deductible and/ or copayment requirements.
- Automated demographic and financial verification

Eligibility Verification

- Connects with the payer database and brings back the data to plant in the notes field of the registration screen
- Before patient interview is complete, a registration employee can see the outcome of the eligibility query
- Alert employees to patients' co-insurance or deductible requirements and whether those requirements have been met
- Queries to determine if the insurance card is out of date
- Required authorizations can be obtained and payment denials due to lack of authorization can be averted.
- Collaborating with clinical staff members

Collection Referral Principles

- An account 90 days past due is worth only eighty-three cents on the dollar
- An account 180 days delinquent is worth only sixty-seven cents on the dollar
- An account one year past due is only worth forty-five cents on the dollar

Internal vs. External Resources

- AR is all about “touches”—and they are EXPENSIVE
- Why Industry is Typically Understaffed
- Exposition of options for Providers
- ROI Scenarios

Vendor Analysis

- Get References
- Avoid Offshore
- Site Visits
- NET return counts, most get “blinded” by rate quote

Spousal Liability

In Michigan, an individual is not liable for the necessary medical care of his or her spouse. See: North Ottawa Community Hosp. v. Kieft, 578 N.W.2d 267 (Mich., 1998).

- Practically speaking: If the patient cannot pay his or her bills, Provider cannot seek payment from the spouse's assets unless the spouse expressly agreed to do so prior to or during treatment.

Wrongfully Denied Claims

Mich. Comp. Laws. Ann. § 500.2006(8)

- Deadline: Clean claims must be paid within 45 days.
- Penalty: A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum.
- A provider has up to one year after the date of service or the date of discharge to bill a health plan in order for a claim to be a "clean claim."

Wrongfully Denied Claims

Mich. Comp. Laws. Ann. § 500.2006(8) (Cont.)

- Information requests: A health plan must notify the provider in writing within 30 days after receipt of the claim by the health plan of all known reasons that prevent the claim from being a clean claim. A provider has 45 days, and any additional time the health plan permits, after receipt of notice of defect in a claim to correct the defect. The 45 days is tolled until the receipt of additional information.

Delayed Claims - Workers Compensation

Mich. Admin. Code r. 418.10116 (Rule 116)

- Deadline: Claims should be paid within 30 days.
- Penalty: If the provider has not received payment within 30 days of submitting a bill, then the provider shall resubmit the bill to the carrier and add a 3% late fee.

Usual and Customary Denials

- Verify that patient is not a member of a contracted PPO.
- Do not accept payer's determination at face value. Demand a detailed:
  - ✓ *itemization of all denied or reduced charges;*
  - ✓ *an explanation of the evidence relied upon in determining that charges were excessive;*
  - ✓ *a printout containing the charges of the other providers against which your facility was compared; and*
  - ✓ *the age of the evidence utilized in the comparison.*

Silent Preferred Provider Organizations

Check your contracts to ensure . . .

- Insurer is not permitted to sell or distribute negotiated rates
- Mandatory notification when payers are added or deleted
- Provider can cancel if network unacceptably expanded
- Logo type and location on card is specified

Pre-Existing Conditions Denials

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- Applies to most group health plans.
- Limits pre-existing condition exclusions:
  - 6 month maximum look-back and
  - 12 or 18 month maximum exclusionary period.
- Credits prior coverage to reduce exclusionary period.
- HIPAA mandates that state law cannot be broader.
- **Never** a pre-existing condition: pregnancy & genetic information.
- Newborns & adopted children added within 30 days are not subject to pre-existing condition exclusions.

Pre-Existing Conditions Denials

Non-Group HMO Health Plans *(Mich. Comp. Laws Ann. § 500.3539)*

- Look back period for a non-group contract cannot be more than 6 months. Exclusion period for non-group contract cannot be longer than 6 months.

Commercial Small Group *(Mich. Comp. Laws Ann. § 500.3406 f(1)(b))*

- For a group policy or certificate covering 2-50 individuals, the look back period is 6 months and the exclusionary period may be up to 12 months.

Commercial Large Group *(Mich. Comp. Laws Ann. § 500.3406 f(1)(c))*

- For a group policy or certificate covering more than 50 individuals, the look back period is 6 months and the exclusionary may be up to 6 months.

Individual Health Plans (*Mich. Comp. Laws Ann. § 500.3406 (f)(1)(a))*

- For an individual covered under an individual policy, the look back period cannot be more than 6 months and the exclusion period cannot be longer than 12 months.

Medical Necessity Denials

- Copy of the criteria carrier utilized to determine medical necessity – is criteria accepted in the industry?
- Specific reasons for the determination – ability to directly refute reason in appeal.
- Information carrier utilized to support its determination – in second level appeal point out records the carrier failed to secure for complete review.
- Credential of the reviewer – require that physician in specialized field review the claim

Pre-Authorization Denials

- Each HMO shall cover and reimburse expenses for care obtained in an emergency by an enrollee without:
  - prior authorization; or
  - regard to the contractual relationship between the provider and the HMO.
- Each HMO shall cover and reimburse expenses for emergency services at a rate equal to the lesser of the following:
  - the usual, customary, and reasonable charge in the HMO's service area; or
  - an amount agreed to between the HMO and the out of network provider.

Emergency Services Denials

Mich. Comp. Laws. Ann. § 500.3406k

- An insurer shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization.
- An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured because of either of the following:

  (a) The final diagnosis; or
  (b) Prior authorization was not given by the insurer before emergency health services were provided.

Conclusion

- Discussion
- Questions
- Contact Information:

Bruce A Nelson
262-510-8000
bnelson@convergentahc.com
AHC, Inc.