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Crowe Healthcare Summit 2019

Nurture Your Network
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Top Revenue Cycle Risks That Could Jeopardize Your Organization

September 18

Presented by:
Harry Kimball
Carol Mort

Introducing Healthcare's Trusted Community:

The Crowe Hive Network

Being successful in your role today looks different than it did even a few years ago. **Engage with a network of those who have been there before you:**

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Agenda

- Overview of Revenue Cycle
- Why Manage Revenue Cycle Risk?
- Key Risks & Mitigation Strategies
  - Front
  - Middle
  - Back

Your presenters

Harry Kimball

is a Healthcare Risk Consulting Vice President. He leads internal audit models, consulting projects, risk assessment projects in the Southeast and is based in Tampa, Florida.

Carol Mort

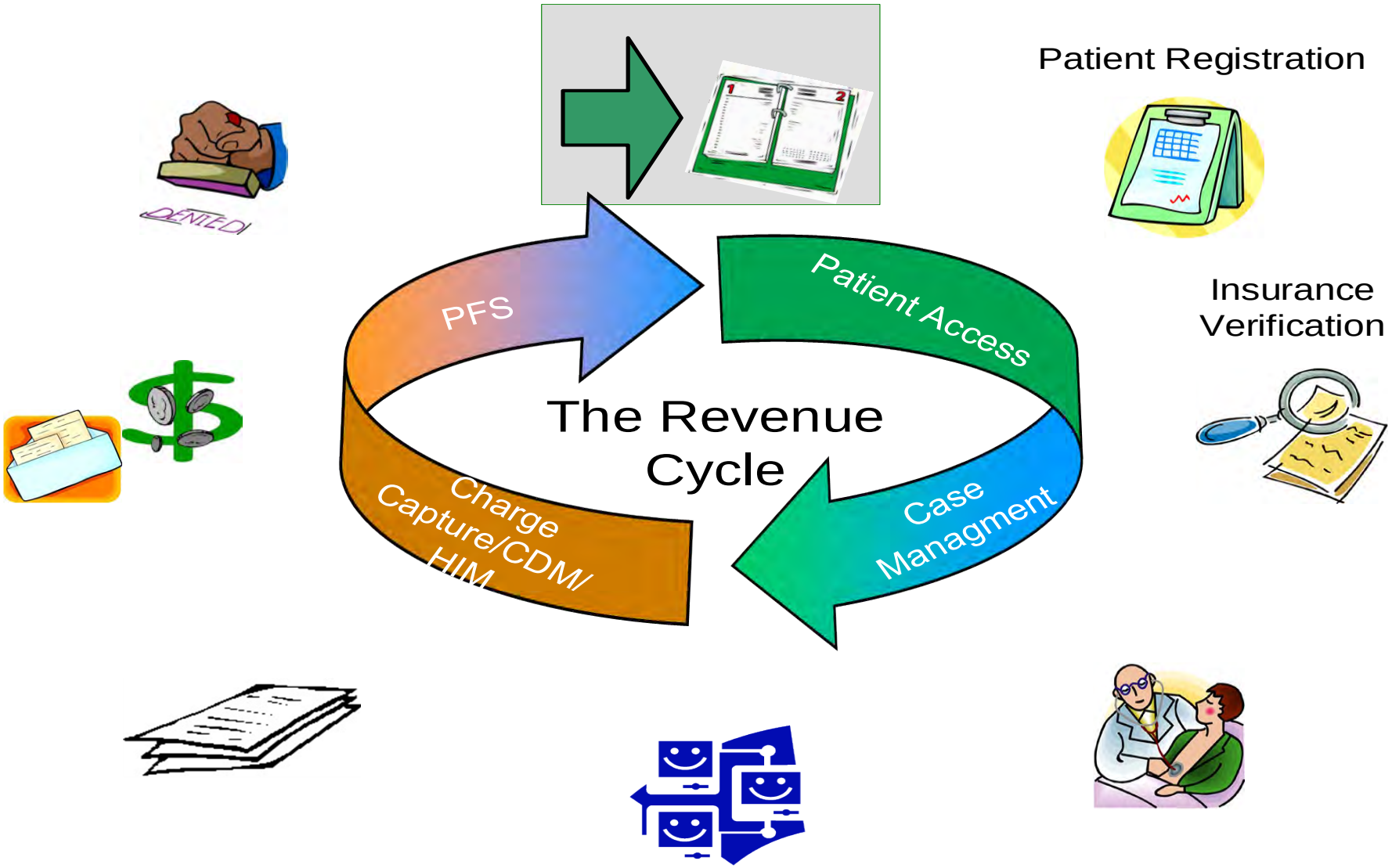
is a Manager in Crowe's Healthcare Consulting Practice. She specializes in internal audits of Revenue Cycle operations and is based in Southern California.

Learning Objectives

- Obtain a high-level understanding of the Revenue Cycle
- Understand why it’s important to manage Revenue Cycle risks
- Identify key risks throughout the Revenue Cycle
- Understand ways to mitigate those risks

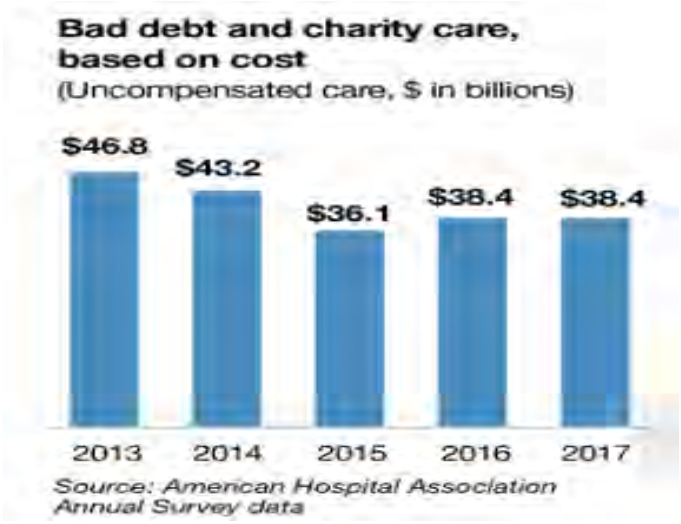
Revenue Cycle Overview

Revenue Cycle Wheel



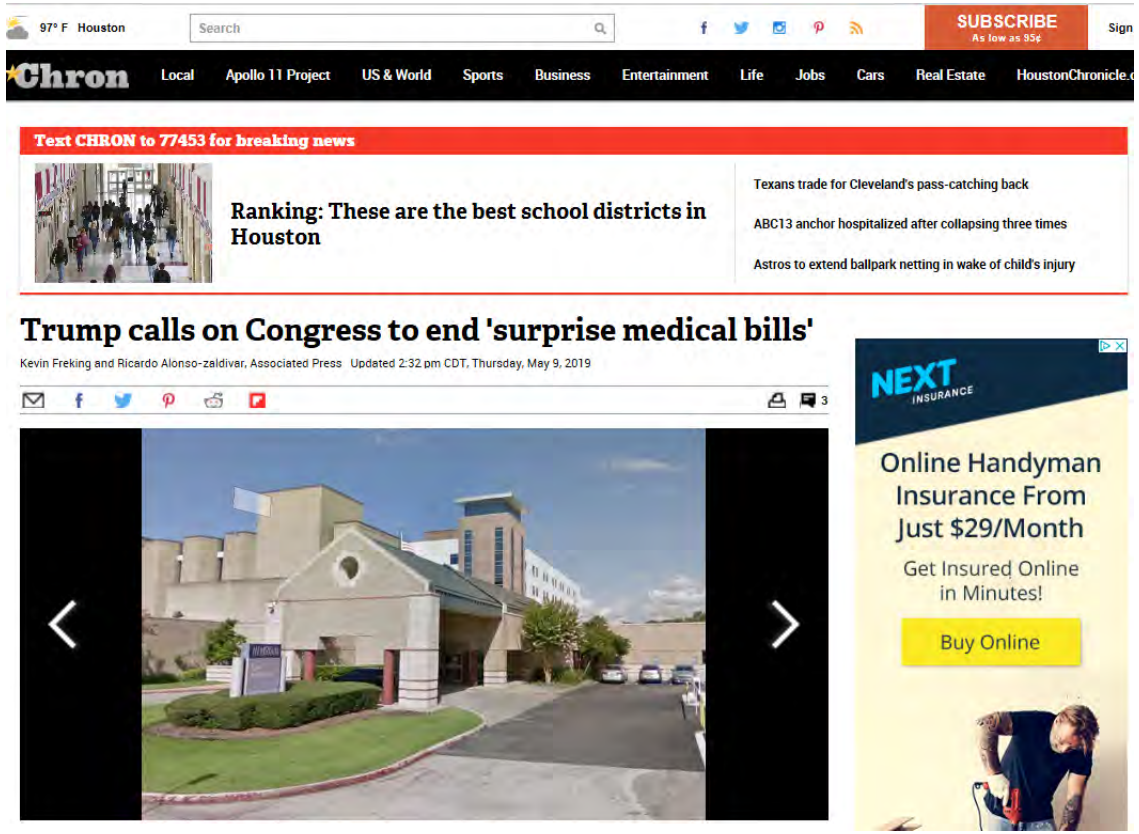
Why Managing Revenue Cycle Risks Matters

Why Managing Revenue Cycle Risk Matters



"Every step in the RCM process has the potential for administrative waste."

"The patient is the new payer."



Front – Key Risks and Mitigation Strategies

Patient Access

Intake the patient and gather the right information according to the right regulation.

Patient Access

Patients are registered / admitted without insurance verification for benefits and eligibility.

- Verification tracked through software or some other means such as account note entry; electronic copies scanned or voice recorded calls.
- Patients without adequate coverage or benefits are referred to financial counselor prior to non-emergent services.
- Patient accounts are prioritized for insurance verification by service type, high dollar and service date.

Patient Access

Patient demographic, financial information, and insurance information is not obtained and verified for accuracy at each encounter.

- Patient information is secured or validated at each encounter with appropriate signatures obtained.
- Verification tracked through software and full documentation is retained.
- Patients without adequate coverage are referred to a financial counselor.
- Comprehensive listing of services with payer pre- auth/ pre cert requirements are routinely updated.
- Policy change discussions with clinicians are routine and ongoing.

Patient Access

Noncompliance with registration regulations may expose a hospital to fines, penalties and possibly the loss of tax-exempt status.

Mitigation Strategy

- Compliance with federal/state regulations surrounding the following forms: MSP, ABN, IM, NPP, EMTALA Patient Tracking log.
- Policies, procedures and protocols clearly established and revisited.
- Departmental monitoring programs.
- Routine Compliance auditing.

Middle – Key Risks and Mitigation Strategies

Charge Capture

Documentation, posting, and reconciliation of charges for services rendered, supplies utilized and drugs administered.

Charge Capture

Inaccurate revenue leading to regulatory exposure and potential lost reimbursement due to charges:

- not posted or not posted timely;
- posted for the wrong services;
- posted for services not provided; and/or
- posted to the wrong account and/or posted for the incorrect quantity.

- A documented process to enter all chargeable procedures and supplies at the time of services.
- Manual, or systematic method, so that all chargeable services, supplies and resources are charged at the time they are provided.
- Process exists to reconcile all chargeable procedures and supplies at the time of service to the charges prior to posting to billing system.

Charge Capture

Lack of understanding of newly installed IT systems and how it interacts with other systems which results in incorrect or missed charges.

- Process established to minimize/address services performed prior to CDM item set up.
- Departmental connection with IT.
- Coordination with Clinical Informatics.
- Involvement with IT in designing controls.
- Breaking down silos.

Charge Capture

Ineffective Charge Description Master (CDM) management leading to error in the charges and contract rates, resulting from error or fraud.

- CDM governance & communication structure.
- Clinicians keep abreast of new chargeable services in their clinical area, identify CDM updates.
- Department manager performs an annual review of the CDM to validate all charge items are present and to remove any obsolete charge codes.
- Formal CDM change management process - CDM changes are mapped correctly to clinical systems and changes are tested before being placed into production.

Charge Capture

Belief that responsibility for revenue integrity is NOT the responsibility of the clinical function.

- Management accountability in the department for accurate and timely processing of charges.
- Third Party staff is held accountable for accurate and timely processing of charges, billing and claim filing.
- Staff have the skills/expertise to understand the charge system, how charges are input and hospital management's expectations for their role in the revenue cycle.

Coding

Proper coding leads to proper payments.

Coding Compliance

Insufficient/unclear medical documentation could result in erroneous code assignment, charges, and inaccurate data reporting, which ultimately leads to incorrect reimbursement, and poor record-keeping.

- Clinical Documentation Improvement (CDI) steering committee, clearly documented program objectives aligned with organizational goals.
- Physician query monitoring process is used to track the level of responses and response times.
- Metrics are established, and reports are reviewed, for various facets of the CDI program.
- Regular collaboration/feedback with HIM Coding to identify documentation gaps and to determine the process for unanswered queries at patient discharge.

Coding Compliance

Inaccurate assignment of codes and charges resulting in incorrect reimbursement.

- Appropriate review structure for manual codes.
- Validation of certification for all coders.
- Ongoing, routine audits of coding compliance.

Back - Key Risks and Mitigation Strategies

Billing

Submit claims to the right payer, with the right information at the right time (as soon as possible!)

Billing

Claims do not meet payer requirements, resulting in costly rework, increased denials and lost reimbursement.

Mitigation Strategy

- Build Billing Edits Based on Payer Requirements.
- Monitor Clean Claim Rates.
- Analyze Failed Edits and Edit Overrides.
- Identify Root Cause.
- Develop Process Improvements.
- Continue Monitoring!

Billing

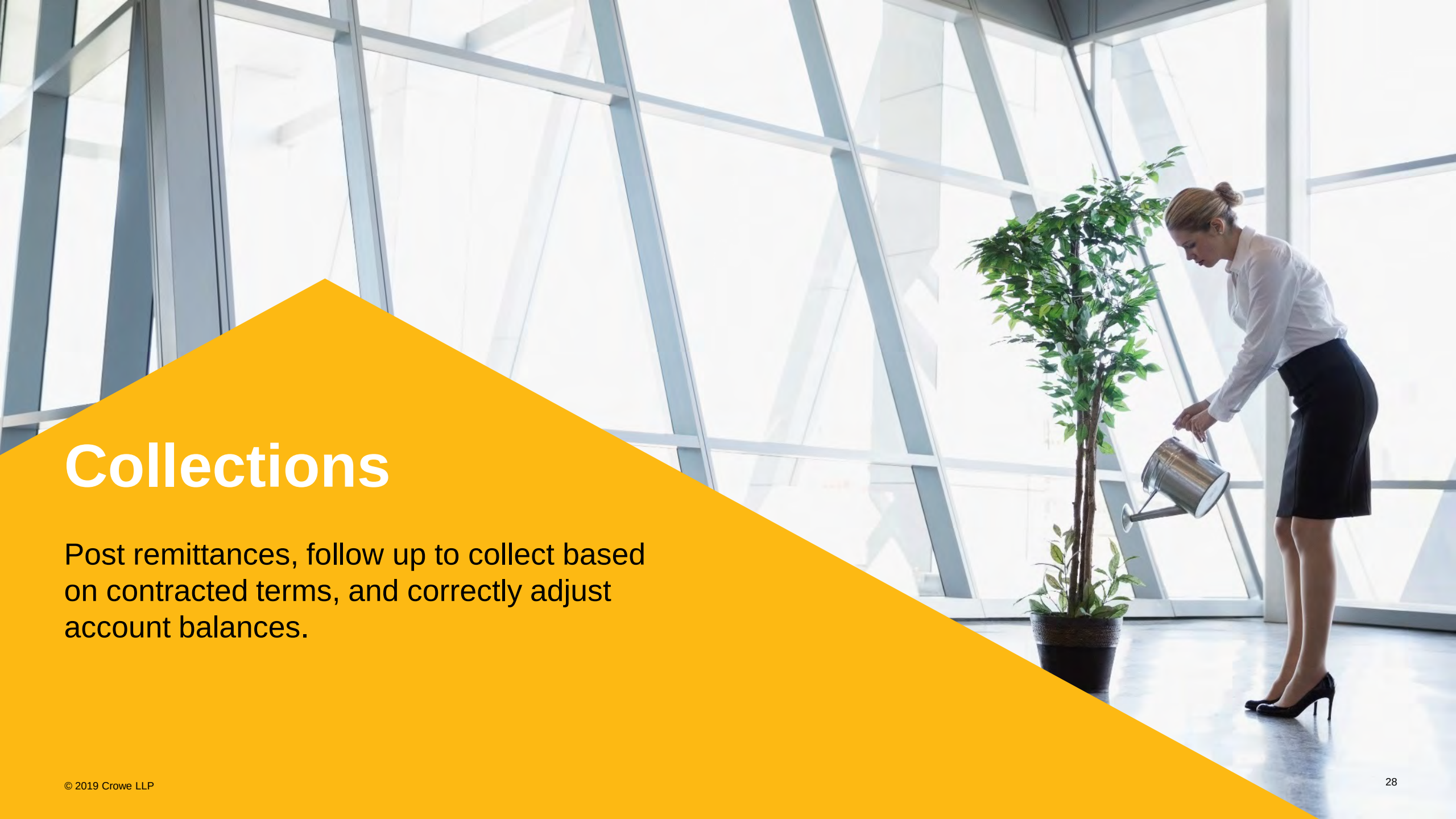
Untimely billing, resulting in delayed cash flow and lost revenue due to timely filing.

Monitor and follow up on aged unbilled accounts:

- Discharged Not Final Billed (DNFB)
- Final Bill Not Sent (FBNS)

Define protocols for billing secondary payers and patients.

Monitor small balances.



Collections

Post remittances, follow up to collect based on contracted terms, and correctly adjust account balances.

Remittance Posting

Untimely or inaccurate posting, impacting cash flow and follow up priorities.

- Monitor for timely posting of 835s and manual remittances.
- Categorize Claims Adjustment Reason Codes (CARC) and route for resolution.
- Map payment and adjustment codes to the appropriate general ledger accounts.
- Research unapplied/unidentified payments.
- Reconcile bank statements.

Follow Up

Untimely follow up on denials or underpayments, delaying reimbursement.

Mitigation Strategy

- Document payer specific follow up protocols.
- Monitor aged and untouched accounts/unworked tasks.
- Use robust Contract Management tool to calculate expected payment.
- Identify underpayments to prioritize follow up.
- Use predictive analytics to prioritize accounts for follow up based on collectability.

Adjustments

Accounts are written off prematurely for the wrong amount or the wrong category. (*Contractuals, Charity Care, Denials, Bad Debt, Administrative Adjustments)*

- Define adjustment types, protocols and approval levels/protocols.
- Verify automated “scripts” to net down accounts are accurate.
- Training on manual adjustments.
- Risk-Based QA/Analytics to identify potential errors.

Credit Balances

Minimize credit balances, research and refund timely, comply with unclaimed property laws and Medicare reporting requirements.

Credit Balances

Credit Balances are not worked timely

Noncompliance with State Escheat Laws and Medicare credit balance reporting requirements (CMS-838)

Mitigation Strategy

- Understand what is causing Credit Balances.
- Monitor Aged Credit Balances.
- Know State Escheat Laws.
- Solid process for researching and reporting to Medicare.
- Automated resolution/machine learning tools.

Denials Management

Understand why denials occur and take action to prevent going forward.

Denials Management

Denials are not analyzed for prevention and reduction, impacting net revenue.

Mitigation Strategy

- Establish governance and accountability with a multidisciplinary team.
- Categorize, track and trend initial and final denials.
- Analyze root causes by service line, department, payer.
- Develop and monitor process improvements to address root causes.

Key Takeaways

Top Revenue Cycle Risk Categories:

- Patient Access
- Charge Capture
- Coding
- Billing and Collections
- Denials Management

Healthcare organizations need to continually assess, prioritize and mitigate revenue cycle risks to keep patients happy, strengthen financial position, and maintain compliance.

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Thank you

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