Making Bank: Managing and Monitoring Your Revenue Cycle

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Andrew Davis and Malita Scott and Sharon Sagarra do not have any financial conflicts to report at this time.
Learning Objectives

• Analyze key fundamentals for best practice revenue cycle management operations

• Implement a revenue-cycle process that maintains profitability

• Examine technology that will aid you in making process more efficient

About Your Presenters

Andrew Davis
Senior Manager
Drew brings an extensive background in strategic revenue cycle management, complemented with his deep knowledge of clinical operations and IT systems support. Clients find particular value in his ability to bridge complex concepts and facilitate change management across these often disparate areas.

In Drew’s time at ECG, he has partnered with healthcare providers across the country to optimize structural, operational, and financial performance. Drew has knowledge of and a continued interest in consolidated business office models, integration of revenue cycle activities across health systems, use of IT as a strategic driver for organizational change, technology-directed process optimizations, and quantitative-guided labor management.

Prior to his work at ECG, Drew was an administrative fellow and department manager at Duke University Health System. He led the health system’s preregistration team and spent much of his time optimizing system design and operations following a major system conversion.

Malita Scott
Associate Principal
Malita’s expertise working with ambulatory networks is of tremendous value to her clients at a time when the traditional boundaries between inpatient and outpatient care are being redrawn.

Malita has devoted her 15-year career to helping ambulatory providers improve performance, enhance patient care, optimize work flows, and lower costs. She has led health systems through major transitional change, including organizational turnarounds and alignment transactions, and clients value her ability to build strong relationships with leadership, physicians, and staff. Malita has helped her clients position for success under healthcare reform, including identifying opportunities to establish clinical integration and value-based ambulatory networks.

She has worked with her clients to create highly efficient, patient-centered ambulatory care settings and has helped a number of organizations achieve multimillion-dollar savings. Malita’s experience spans multispecialty adult and pediatric hospitals in both community and academic settings.
Tackling today’s complex and interconnected healthcare problems requires knowledge and expertise across multiple disciplines, and that’s what ECG delivers to our clients every day. With four core competencies of strategy, finance, operations, and technology, we provide smart counsel and sustainable solutions that are transforming healthcare delivery.

More than 225 professionals operate out of ECG’s offices in Atlanta, Boston, Chicago, Dallas, Minneapolis, San Diego, San Francisco, Seattle, St. Louis, and Washington, D.C.

We’re leading healthcare forward, one organization at a time.

### Service Offerings

**STRATEGY**
- Enterprise strategy
- Service line strategy
- Physician strategy and alignment
- Health reform and ACO strategy
- Transactions and affiliations
- Organizational design and development

**FINANCE**
- Business and financial advisory services
- Payor contracting and reimbursement
- Provider compensation planning
- Valuation services
- Industry benchmarking

**OPERATIONS**
- Performance improvement
- Care model transformation
- Patient access
- Revenue cycle optimization

**TECHNOLOGY**
- IT system strategy
- IT system implementation and optimization
- System integration
- Patient engagement
- System reporting enhancement
Today’s Agenda

I. Market Trends
II. Revenue Cycle Overview
III. Positioning for the Future
IV. Conclusion

Market Trends
Driving Forces

Multiple market factors are changing the landscape in which revenue cycle management (RCM) services are deployed among medical group organizations.

Rising Costs: US healthcare administrative costs have continued to rise, requiring administrators to effectively manage the revenue cycle in order to optimize efficiency and maximize reimbursement.

Changing Reimbursement Models: With changes in how services have been traditionally reimbursed (from fee for service to value-based care), providers must learn to effectively manage clinical and financial risk in varying degrees.

Patient Consumerism: From higher deductibles to increased premiums, patients are shouldering a greater burden of out-of-pocket costs and becoming more educated in decisions around what services they want and how much they are willing to pay for them.

Third-Party Outsourcing: Multiple third-party vendors are now entering the marketplace to provide end-to-end RCM services; however, varying degrees of success among vendors often lead practices to contemplate outsourcing versus insourcing.
Market forces are driving medical group operators to react dramatically and adapt to these dynamic conditions. Incremental practice-level changes are not sufficient to support needs of today’s healthcare organizations.

- Financial conditions require *reductions in cost* in order to maintain even status quo operations.
- Lower reimbursement requires providers to *adapt advanced payment models* and *recruit revenue cycle talent* to manage these systems.
  - More time and resources must be allocated to *identify patient liability* and *educate patients on their benefit plans*.
  - Limited access to talent requires *use of third-party vendors or costly temporary labor*.

Market Trends
First Key Question

Which market trend or force has the greatest impact on your practice’s finances and operations?
Market Trends

Importance of Revenue Cycle

Medical groups are losing 3% to 5% of their net revenue from inadequate RCM processes and procedures.

- Front-end revenue cycle data capture has critical downstream effects on net collections.
- Scheduling, registration, and insurance eligibility verification have a direct impact on bottom-line performance.
- Appropriate classification of government and commercial insurance is key.
- Patients are selecting higher-deductible plans.
- Collecting on self-pay accounts continues to create challenges for healthcare organizations and medical practices.
- Healthcare consumers are becoming more selective in determining where they get their services.
- Payment delays/rejections contribute to higher revenue cycle operation costs.
- Insurance denials and underpayments are costly to identify and address.
- Re-work associated with inefficient work flows results in a higher cost to collect.

Effective RCM requires an investment in people, processes, and technologies to ensure proper revenue, resource allocation, and compliance.

Market Trends

Second Key Question

What can medical groups do to contain costs and increase revenue in today’s financially challenging healthcare environment?
### Revenue Cycle Overview

**Introduction**

The revenue cycle is defined as all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue. Several key considerations are listed below.

#### KEY CONSIDERATIONS

<table>
<thead>
<tr>
<th>Functional Areas:</th>
<th>Essential Management Elements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Front End: Pre-visit and point-of-service (POS) functions</td>
<td>• Accountability</td>
</tr>
<tr>
<td>• Mid-Cycle: Coding and charge capture</td>
<td>• Management/governance</td>
</tr>
<tr>
<td>• Back End: Billing and collections</td>
<td>• Transparency/reporting</td>
</tr>
<tr>
<td></td>
<td>• Revenue integrity</td>
</tr>
<tr>
<td></td>
<td>• Vendor management</td>
</tr>
</tbody>
</table>

**Nuances of Hospital Versus Professional Fee:**

- Patient types
- Coding process
- Claim forms
- Reimbursement mechanism
- Payment/adjustment posting level

**Affected Organizational Layers:**

- Providers/Management/Staff: Productivity, performance, engagement
- Operations: Process efficiency, centralization
- Infrastructure: Systems, reports, tools, automation

**As shown on the next slide, functional areas of the revenue cycle are not isolated in just “the billing shop.” Effective management requires shared focus and accountability across the entire organization.**

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### Revenue Cycle Overview

**Process Flow and Functional Area Summary**

#### Front-End Functions

**Pre-Visit and POS Activities**

<table>
<thead>
<tr>
<th>Appointment Scheduling</th>
<th>Registration and Eligibility</th>
<th>Referral Management</th>
<th>Arrival/Check-In</th>
<th>Patient Care Event and Checkout</th>
<th>Coding and Documentation</th>
<th>Charge Capture and/or Charge Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule appointments.</td>
<td>Make reminder phone calls.</td>
<td>Gather demographic info.</td>
<td>Obtain preauthorization or referral if needed.</td>
<td>Verify all demographic and insurance data.</td>
<td>Clinician sees patient.</td>
<td>Post codes to billing system.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obtain and verify insurance/payor info.</td>
<td>Contact payer for notification of treatment.</td>
<td>Collect any patient liability.</td>
<td>Any return visits are scheduled and referrals are initiated.</td>
<td>Create claim or invoice to bill insurance company using coded encounter.</td>
</tr>
</tbody>
</table>

#### Mid-Cycle Functions

**Coding and Charging**

- Claim Edit and Submission
  - Identify any errors and/or missing info.
  - Submit claims to insurance for processing.
- Payment Posting and Cash Management
  - Receive payer adjudication information and enter into billing system.
  - Ensure cash is deposited into appropriate bank accounts and reconciled.
- Insurance Denials and Follow-Up
  - Follow up on denials or unprocessed/no-response claims.
  - Initiate resolution or correction, re-bill, and/or write-off if necessary.
- Patient Inquiry and Self-Pay Follow-Up
  - Bill post-insurance self-pay balances to patients.
  - Process all patient-initiated correspondence.
### Revenue Cycle Overview

#### Front End

<table>
<thead>
<tr>
<th>Common Pitfalls</th>
<th>Keys to Success</th>
<th>Performance Measures</th>
</tr>
</thead>
</table>
| **Appointment Scheduling** | • Using consistent appointment types, scheduling templates, and protocols  
• Reducing appointment backlogs and utilizing locum tenens  
• Verifying registration data at time of scheduling  
• Making pre-visit reminder calls | • Patient on-time and no-show rates  
• Provider utilization rate |
| **Registration and Eligibility** | • Timely and accurate front-end data collection  
• Enhanced pre-registration at time of scheduling  
• Required fields in practice management system  
• Robust and user-friendly eligibility verification tool  
• Ongoing training for registration staff | • Number of preregistrations completed prior to visits  
• User-specific registration accuracy reports  
• Claim rejections and denials related to insurance eligibility or patient demographics |
| **Referral Management** | • Training, education, and enhanced front-end staff accountability  
• Payor referral requirements review and public summaries  
• Frequently updated system logic  
• Centralized team  
• Review of related denials for process improvement  
• Organizational scheduling policies | • Number of authorization denials, segmented by responsible staff  
• Number of non-emergent appointments scheduled within payor authorization periods |
| **Arrival/Check-In** | • Require training, education, and enhanced front-end staff accountability  
• Configure billing system to notify staff of pre-visit balances  
• Provide staff scripting for patient collections  
• Post POS payments at the site of service | • Total POS collections by user  
• Percentage of co-pays collected at POS  
• Percentage of self-pay A/R attributable to co-pays not collected at POS |
Revenue Cycle Overview

Front End (continued)

Common Pitfalls
- Limited physician engagement or education regarding administrative payor requirements
- Patients leaving clinic with no formal administrative checkout

Patient Care Event and Checkout

Keys to Success
- Provide physician education, reinforced with system notifications
- Require patients to stop at front desk after visit

Revenue Cycle Overview

Mid-Cycle

Common Pitfalls
- Insufficient provider documentation
- Improper provider tools and education for coding
- Consistently up- or down-coding
- Use of noncoders for complex coding decisions

Coding and Documentation

Keys to Success
- Ongoing coding and clinical staff training
- Timely updates to medical record templates and “pick lists”
- Provider coding and documentation audits
- Centralized coding team

Revenue Cycle Overview

Mid-Cycle

Performance Measures
- Number of patients checked out by administrative staff
- Number of follow-up visits/referrals scheduled at checkout
- Number of missed authorizations for in-office procedure

Charge Capture and/or Charge Entry

Performance Measures
- Type and distribution of charged CPT codes and modifiers
- Number of insurance coding denials
- Coder review backlog
- Provider coding audit scores

- Missing charge tickets and/or encounters
- Provider charge lag
- Charge entry backlog
- Total charges entered per period per charge entry FTE

- Order entry procedure with no deviation
- Real-time charge submission through EHR
- Review of missing encounter report
- Standardized encounter forms across all clinics

- Insufficient coordination with clinical departments/practices
- High charge lag days
- Missing charge tickets

- Missing charge tickets and/or encounters
- Provider charge lag
- Charge entry backlog
- Total charges entered per period per charge entry FTE
### Revenue Cycle Overview

#### Back End

<table>
<thead>
<tr>
<th>Common Pitfalls</th>
<th>Keys to Success</th>
<th>Performance Measures</th>
</tr>
</thead>
</table>
| **Claim Edit and Submission** | • Electronic claim submission not utilized  
• Misunderstood paper and electronic claim programming requirements  
• Inadequate management of claim rejections/edits  
• Not loading payer rejections as pre-bill claim edits | • Use electronic claim submission when possible  
• Ensure the registration process is comprehensive  
• Have a simple process for secondary insurance submission  
• Determine possible pre-bill edits from denials data | • Number of claims processed  
• Number of claims rejected  
• Number of claims in edit status  
• Claim lag (charge entry date to claim submission date) |

| **Payment Posting and Cash Management** | • Poorly trained staff  
• High backlogs of unposted denials and zero-pay remittances  
• Minimal batch reconciliation procedures  
• Unmonitored payment posting backlogs | • Use of electronic remittances  
• Lockbox services to sort mail and deposit checks  
• Daily reconciliation of deposited cash to posted batches  
• Ongoing training for staff, with regular quality audits | • Payments posted  
• Unposted backlog  
• Payment posting lag time  
• Credit balances  
• Unallocated payments |

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#### Back End (continued)

<table>
<thead>
<tr>
<th>Common Pitfalls</th>
<th>Keys to Success</th>
<th>Performance Measures</th>
</tr>
</thead>
</table>
| **Insurance Denials and Follow-Up** | • Billing system efficiency functions not utilized  
• Not aggressively appealing insurance company denials  
• Follow-up on staff performance and productivity not monitored  
• Recurring denial issues | • Prioritize A/R follow-up.  
• Create standard forms, letters, etc.  
• Develop working relationships with insurance companies  
• Review denial trends and root causes  
• Implement performance and quality expectations | • Days in A/R  
• Gross and net collection rates  
• A/R aging  
• A/R by insurance |

| **Patient Inquiry and Self-Pay Follow-Up** | • Imprecise patient collections cycle  
• Inconsistent time-of-service collections  
• Collection or early-out agencies not used  
• High levels of bad debt  
• Poor customer service and patient satisfaction | • Maximize inbound and outbound call technology  
• Establish firm self-pay policy, allowing minimal deviation  
• Engage third-party vendors  
• Employ advanced analytics | • Payments received per mailed statement  
• Number of patients enrolled in payment plans  
• Customer service department scores  
• Collection agency recovery percentage |
Revenue Cycle Overview

Key Influencers

Several outside and supporting functions influence the revenue cycle process and require collaboration with a variety of business units across the medical practice.

**SAMPLE INFLUENCERS**

- Provider enrollment and credentialing
- Managed care contracting analysis
- Underpayment variance detection
- Business intelligence
- Information systems support
- Legal and compliance
- Staff training and quality oversight
- Scanning, document storage, and retrieval
- Clerical support
- Miscellaneous other functions necessary to support billing operations

Depending on the practice, these functions can be housed within the revenue cycle unit(s), viewed as partnerships across the medical group, or in some cases, supplemented by external vendor support.

Revenue Cycle Overview

Common Performance Issues

<table>
<thead>
<tr>
<th>DATA QUALITY</th>
<th>ACCOUNTABILITY</th>
<th>STAFF AND SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inconsistent demographic and eligibility verification</td>
<td>• Work standards lacking</td>
<td>• Right work not assigned to right staff</td>
</tr>
<tr>
<td>• Provider documentation and encounter forms incomplete</td>
<td>• Policies and procedures not documented/updated</td>
<td>• Staff without adequate system/process training</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MANAGEMENT AND COMMUNICATION</th>
<th>PROCESS AND TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Understanding of revenue cycle varies across management</td>
<td>• Process inconsistencies</td>
</tr>
<tr>
<td>• Limited management information provided</td>
<td>• Patient balances not collected on front end</td>
</tr>
<tr>
<td>• Communication between front and back end limited and/or strained</td>
<td>• Control points not established to reduce leakage/backlogs</td>
</tr>
<tr>
<td></td>
<td>• Staff without access to appropriate tools</td>
</tr>
<tr>
<td></td>
<td>• IT modules for increased efficiencies not installed</td>
</tr>
<tr>
<td></td>
<td>• Interfaces not established</td>
</tr>
</tbody>
</table>
Positioning for the Future
Metrics: Introduction to Performance Management

All too often, the reasons for performance measurement inadequacies are the result of common pitfalls and benchmark creep. Successfully implementing an effective strategy relies on developing a cohesive framework for management.

Common Reasons for Failed Performance Management

- Available or reported data is not trustworthy.
- Measures are misaligned with organizational vision and goals.
- Data is not actionable.
- Measures are too complex or difficult to interpret.
- Distribution frequency is low or inconsistent.
- There is no comparison mechanism to determine effectiveness or success.
- The organization or business unit has limited accountability.
- Reported measures don't correspond to employee role.

Elements of Successful Performance Management

• Developing a common cultural foundation
• Creating the tools to measure and manage performance
• Making measurable and testable changes

Market Trends
Third Key Question

What metrics are used to monitor the health of your practice’s revenue cycle?
Positioning for the Future

Metrics: Summary

A provider’s financial well-being is nearly always tied to the revenue cycle of the clinical practice. A clearly defined and understood suite of KPIs is necessary to ensure appropriate engagement and support.

- Patient opening balance
- Revenue
- Write-offs
- Miscellaneous

- Gross collection rate
- Net collection rate

- First-pass denial rate
- Terminal denial rate

- Days in A/R
- A/R aging

- Bad debt as a percentage of charges
- Patient collection efficiency

- Payor mix
- Charge lag

A/R

SELF-PAY

COLLECTIONS

DENIALS MANAGEMENT

PRODUCTIVITY

MISCELLANEOUS

There are several transaction-based figures a medical group should use to monitor provider productivity and revenue cycle volumes.

PATIENT OPENING BALANCE

Charges: Set by provider organization and defined as the dollar value for services performed

REVENUE

- Gross Collections: Total debit payments collected by an organization
- Refunds: Returned credit balances that result from erroneous payment to the provider when there is no open balance or the issuing party is not responsible

WRITE-OFFS

- Controllable Write-Offs: Typically uncollectible payor-initiated denials or self-pay balances
- Non-controllable Write-Offs: Adjustments that are typically not expected to be recovered (e.g., write offs)

MISCELLANEOUS

- Work RVUs (WRVUs): Provider component of a total relative value unit (RVU) measure, set by CMS at the CPT level
- Patient Visits: Count of patient visits within a certain period
- CPT Volumes: Count of all CPT code units generated within a certain period
### Positioning for the Future

#### Metrics: Typical KPIs by Category

The commitment to measuring and monitoring performance is key for making process adjustments and setting appropriate goals.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>TERM</th>
<th>PURPOSE</th>
<th>ACCEPTABLE PERFORMANCE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A/R</td>
<td>Days in A/R</td>
<td>Calculates how long it takes for services to be paid</td>
<td>&lt;40 days</td>
</tr>
<tr>
<td></td>
<td>Percentage of A/R Over 120 Days</td>
<td>Measures proportion of total receivables with decreased collectability</td>
<td>15%-20%</td>
</tr>
<tr>
<td>Collections</td>
<td>Gross Collection Rate</td>
<td>Demonstrates total payments recorded as a percentage of charges</td>
<td>&gt;30%</td>
</tr>
<tr>
<td></td>
<td>Net Collection Rate</td>
<td>Calculates percentage of total possible revenue collected</td>
<td>&gt;92%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>Bad Debt as a Percentage of Charges</td>
<td>Indicates effectiveness of self-pay collection efforts and unrecoverable patient write-offs</td>
<td>&lt;1.75%</td>
</tr>
<tr>
<td></td>
<td>POS Collections Percentage</td>
<td>Calculates percentage of patient revenue collected prior to service delivery</td>
<td>4%-6% total revenue</td>
</tr>
<tr>
<td>Denials Management</td>
<td>First-Pass Denial Rate</td>
<td>Indicates number of submitted charges denied by the payor</td>
<td>&lt;6%</td>
</tr>
<tr>
<td></td>
<td>Terminal Denial Rate</td>
<td>Measures frequency of unrecovered denials</td>
<td>&lt;2.5%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Charge Lag</td>
<td>Determines time from service delivery to system revenue recognition</td>
<td>&lt;Two days E&amp;M</td>
</tr>
<tr>
<td></td>
<td>Payor Mix</td>
<td>Payor mixes can be “favorable” or “unfavorable,” but these generally only help to frame performance, not influence it</td>
<td>n/a</td>
</tr>
</tbody>
</table>

The commitment to measuring and monitoring performance is key for making process adjustments and setting appropriate goals.

### Positioning for the Future

#### Metrics: KPI Relationships

No single KPI can tell the entire story of an organization’s revenue cycle. When revenue cycle metrics are available, data points must be evaluated in tandem to isolate and troubleshoot root-cause issues.

- **A/R Days & Net Collection Rate**
  - Of all the revenue KPI relationships, the link between these two metrics is the strongest.
  - There should be an appropriate balance between the average age of A/R and maximizing provider collections.

- **A/R Days & Payor Mix**
  - A skewed distribution of payors should be evaluated very closely.
  - RCM staff should be aware of the payor’s impact on A/R days.

- **First-Pass Denial Rate & Terminal Denial Rate**
  - The difference between these two figures represents the success of appealing denials.
  - It is preferential to invest in pre-bill activities to produce a clean claim that is payable under payor guidelines on a first pass.
Positioning for the Future
Metrics: KPI Relationships (continued)

**A/R Days**

- **Bad Debt as a Percentage of Charges**
  - If A/R days are high and bad debt is low, it could mean no bad debt placements have been issued recently.
  - High bad debt placement and lower A/R days could indicate a premature bad debt adjustment and minimal attention to/effort regarding self-pay and bad debt accounts.

**Payor Mix**

- **Bad Debt as a Percentage of Charges**
  - High bad debt can often be explained by a large self-pay component in the payor mix.
  - Payors with high portions of patient cost sharing could indicate an above-average self-pay balance placement.

**Transaction Volumes Trending**

- There is value in reviewing raw transaction volumes to ensure corresponding rates of growth.
- A provider should monitor collections, contractual adjustments, and charges together to determine root causes for swings in gross collections and/or A/R.

These KPI relationships are not exhaustive, but do represent the primary metrics an organization should use when evaluating performance.

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**Positioning for the Future**
Organizational Structure and Governance

Our experience is that most moderately-sized physician groups find success deploying a hybrid organizational model, which leverages economies of scale while also locating functional responsibilities where it can be serviced most efficiently.
Positioning for the Future
Organizational Structure and Governance (continued)

Appropriate leadership engagement and supporting organizational structures are required to ensure that the revenue cycle has the right infrastructure, skills, and tools.

Organizational alignment is critical to ensure that a high-performing revenue cycle process is a top priority.

Both RCM and physician collaboration are integral to high-performing practices.

Establish accountability for every process of the revenue cycle

Foster an attitude of gratitude.

Positioning for the Future
Accountability

Higher-performing organizations have high levels of stakeholder engagement “up and down” the organization. Practice leaders should create cascading balanced scorecards that build toward common organizational goals.

<table>
<thead>
<tr>
<th>SAMPLE POSITION</th>
<th>SAMPLE POSITION OBJECTIVES</th>
<th>SAMPLE RELATED KPIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>Creditworthiness</td>
<td>Bond rating</td>
</tr>
<tr>
<td></td>
<td>Sufficient financial performance</td>
<td>Net revenue</td>
</tr>
<tr>
<td>CFO</td>
<td>Financial solvency</td>
<td>Days cash on hand</td>
</tr>
<tr>
<td></td>
<td>Productive operations and workforce</td>
<td>Total operating margin</td>
</tr>
<tr>
<td>Vice President, Revenue Cycle</td>
<td>Maximized cash collections</td>
<td>Total cash collections</td>
</tr>
<tr>
<td></td>
<td>Maximized cash acceleration</td>
<td>Days in A/R</td>
</tr>
<tr>
<td></td>
<td>Efficient operating costs within unit</td>
<td>Cost to collect</td>
</tr>
<tr>
<td>Director, A/R Management</td>
<td>Maximized cash collections</td>
<td>Days in A/R</td>
</tr>
<tr>
<td></td>
<td>Maximized cash acceleration within unit</td>
<td>A/R &gt;120 days</td>
</tr>
<tr>
<td></td>
<td>Efficient operating costs within unit</td>
<td>Denial rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff productivity/quality scores</td>
</tr>
<tr>
<td>Manager, Commercial Payor A/R</td>
<td>Maximized cash collections</td>
<td>Days inventory on-hand</td>
</tr>
<tr>
<td></td>
<td>Maximized cash acceleration within unit</td>
<td>Average invoice age</td>
</tr>
<tr>
<td></td>
<td>Efficient operating costs within unit</td>
<td>Avoidable denial write-offs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff productivity/quality scores</td>
</tr>
<tr>
<td>Patient Account Representative</td>
<td>Maximized cash collections</td>
<td>Invoices worked per day</td>
</tr>
<tr>
<td></td>
<td>Maximized cash acceleration within unit</td>
<td>Quality of worked invoices</td>
</tr>
</tbody>
</table>

Position-level KPIs should be a key component of employee performance reviews. This impacts change in daily work, routines, compensation, and rewards.
Migrate from “jack of all trades” to focused task model.

Tightly integrate work standards into job duties and evaluations (see table).

Implement workforce management best practices to minimize costs.

Exert extra due diligence when hiring new staff.

Update employee handbook, orientation, and training materials to reflect process changes.

Implementing uniform work standards enables management to more accurately inventory backlogs of work, monitor employee accountability, and quantify necessary staffing levels.

<table>
<thead>
<tr>
<th>STAFFING FUNCTION</th>
<th>SAMPLE PRODUCTIVITY MEASURES</th>
<th>SAMPLE QUALITY AUDIT CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Front-End</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central scheduling</td>
<td>• 80% of work day in &quot;ready&quot; status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Average call handle time of &lt;4 minutes</td>
<td>• Specialty-specific scheduling protocols followed</td>
</tr>
<tr>
<td></td>
<td>• Specialty-specific scheduling protocols followed</td>
<td>• Registration quality</td>
</tr>
<tr>
<td></td>
<td>• Average call handle time of &lt;4 minutes</td>
<td>• Courteousness and helpfulness to caller</td>
</tr>
<tr>
<td>Insurance verification</td>
<td>• 15 visits per hour verified</td>
<td>• Coverage verified and documented</td>
</tr>
<tr>
<td></td>
<td>• Verifications completed &gt;2 days out from appointment date</td>
<td>• Correct filing order</td>
</tr>
<tr>
<td>Registration/arrival</td>
<td>• 95% of arrived visits verified</td>
<td>• Benefit detail and patient financial estimates recorded</td>
</tr>
<tr>
<td></td>
<td>• 75% of visits with co-pay or prior balance collections</td>
<td>• Eligibility denial rate</td>
</tr>
<tr>
<td>Preauthorizations</td>
<td>• 8 authorizations completed per hour</td>
<td>• Completeness of registration record</td>
</tr>
<tr>
<td></td>
<td>• Authorizations completed &gt;2 days out from appointment date</td>
<td>• Accuracy of registration record</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient forms completed (e.g., COA, MSP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Last verification date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Registration denial rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Payor-specific authorization protocols followed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Authorization denial rate</td>
</tr>
</tbody>
</table>
## Positioning for the Future

### Staffing and Work Standards (continued)

<table>
<thead>
<tr>
<th>STAFFING FUNCTION</th>
<th>SAMPLE PRODUCTIVITY MEASURES</th>
<th>SAMPLE QUALITY AUDIT CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Cycle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coding</td>
<td></td>
<td>Coding audit score</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coding denial rate</td>
</tr>
<tr>
<td></td>
<td>12 professional E&amp;M abstractions per hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 professional surgical abstractions per hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 technical ancillary abstractions per hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 procedural ancillary abstractions per hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 days to final abstraction</td>
<td></td>
</tr>
<tr>
<td>Charge entry</td>
<td></td>
<td>Accuracy against charge tickets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Charge entry-related denial rate</td>
</tr>
<tr>
<td></td>
<td>45 keyed encounters per hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 charge corrections per hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Charge lag of &gt;1 day</td>
<td></td>
</tr>
<tr>
<td>Back-end</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registration/arrival</td>
<td></td>
<td>Accuracy against documented claim edit resolution processes</td>
</tr>
<tr>
<td>Preauthorizations</td>
<td>15 no-response accounts per hour</td>
<td>Timely resolution</td>
</tr>
<tr>
<td></td>
<td>8 denied accounts per hour</td>
<td>Clear and concise documented actions</td>
</tr>
<tr>
<td></td>
<td>Maximum age of seven days in queue</td>
<td>Balanced with write-offs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Action taken based on documented process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appropriate cross-unit engagement (e.g., coding)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage resolved with expected outcome</td>
</tr>
<tr>
<td>Payment posting</td>
<td>150 manual lines posted per hour</td>
<td>Accuracy against ERAs and EOBs</td>
</tr>
<tr>
<td></td>
<td>20 electronic-posted rejections resolved per hour</td>
<td>Missed contractual adjustments</td>
</tr>
<tr>
<td></td>
<td>Payment file age of &gt;2 days</td>
<td>Reconciliation to deposits</td>
</tr>
<tr>
<td>Credit balance</td>
<td>10 credit balances resolved per hour</td>
<td>Accuracy against documented credit balance resolution processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Balanced with write-offs rather than issued refunds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Auto-recoupment in lieu of manually issued refunds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reconciliation to generated refunds</td>
</tr>
<tr>
<td>Self-pay and customer service</td>
<td>80% of work day in &quot;ready&quot; status</td>
<td>Accuracy against documented issues resolution processes</td>
</tr>
<tr>
<td></td>
<td>80% of outbound calls resulting in patient payment or enrollment in payment plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Average self-pay call handle time of &lt;4 minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Average customer service call handle time of &lt;6 minutes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Balanced with write-offs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of proper tone, empathy, and courtesy with patient/caller</td>
</tr>
</tbody>
</table>
Many practices are evaluating the use of outside partners to manage or support the revenue cycle process in order to maintain focus on quality care, improve the patient’s administrative experience, address skilled labor shortages, and sometimes curb costs.

### OUTSOURCING CHECKLIST

<table>
<thead>
<tr>
<th>Item</th>
<th>Complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined policies, procedures, work standards, and business rules.</td>
<td>✔️</td>
</tr>
<tr>
<td>Measurable milestones and deliverables to meet the strategic and operational goals of the organization.</td>
<td>✔️</td>
</tr>
<tr>
<td>Regular reporting and oversight to ensure adherence to the above.</td>
<td>✔️</td>
</tr>
<tr>
<td>Clear understanding of the outsourcing team’s size, skill set(s), commitment, and competing responsibilities.</td>
<td>✔️</td>
</tr>
<tr>
<td>Transparency for the patient (e.g., he/she should not know that customer service/billing staff are not employees of the group).</td>
<td>✔️</td>
</tr>
<tr>
<td>Near-seamless integration with the clinical enterprise (e.g., the clinic staff should not notice a difference).</td>
<td>✔️</td>
</tr>
</tbody>
</table>

Fifth Key Question

What successes or lessons learned has your organization had with third-party vendor support arrangements?
Positioning for the Future

**RCM Technology**

Technology integrated with practice management (PM) systems has the ability to accurately automate many RCM processes, which effectively increases cash flow, decreases staffing need, and reduces redundant costs.

<table>
<thead>
<tr>
<th>TECHNOLOGY</th>
<th>BENEFITS</th>
<th>CONSIDERATIONS</th>
</tr>
</thead>
</table>
| Insurance Eligibility Tools       | • Increases the percentage of insured patients  
• Decreases the number of claims denied, total days in A/R, and bad debt | • Creates additional resource constraints prior to an appointment  
• Requires training of medical office staff who will discuss eligibility with patients |
| Patient Payment Portals           | • Increases patient awareness with respect to payment responsibility  
• Reduces the need for paper bills and collection follow-up | Necessitates integration with an organization’s billing system to avoid inefficiencies in payment posting processes |
| Computer-Assisted Coding (CAC) Software | • Poses a prospective solution to bridge the gap in the loss of productivity due to ICD-10  
• Reduces the need for time-consuming provider coding training | • Creates the potential for additional inaccuracies and increases the need for auditing  
• Can only interpret findings that are documented electronically |
| Denials Management Tools         | Helps prevent and prioritize denials                                                       | Requires active management of the system |

Implementations that involve both IT and operations personnel are most likely to experience the highest level of success.

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**Fifth Key Question**

What unique or innovative technologic tools has your practice integrated into the revenue cycle? Does your organization have near-term plans to implement a new technology?
Conclusion

As the industry evolves, provider organizations will need to continue to make adjustments to attain revenue cycle excellence.

RECOMMENDATIONS

• Complete an operational assessment, benchmarking your organization’s financial performance against available industry data.
• Determine and formalize KPIs to measure and improve performance, creating shared accountability across the organization.
• Standardize and automate processes and tools.
• Invest in new technologies to improve revenue cycle management and the patient experience.
• Evaluate and implement practices that are patient-friendly and will improve patient engagement.
• Develop a best-in-class governance model and team structure to increase integration and communication.
• Centralize functions that can be easily managed remotely, leading to reduced costs and improved efficiencies.

Thank You.

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Case Study: Making Bank: Managing and Monitoring Your Revenue Cycle

Sharon Sagarra, MBA, FACMPE
Practice administrator, Benrus Surgical Associates, Inc. St. Peters MO

Background

Benrus Surgical Associates, Inc.

- Established 1968
- Cover all four major hospitals (comprised of two major Health Systems) in St. Charles County, MO as well as perform cases at two ASCs.
- Current makeup – Five General Surgeons, one subspecializes in Breast Surgery and one subspecializes in Colon Rectal Surgery.
- Only Board Certified Colon Rectal (& Fellow) in St. Charles County, MO.
- I joined as Practice Administrator in December, 2008.
- Entered into Professional Services agreement with BJC Healthcare in 2012.
Change in Processes

Process prior to 6/2017
- Paper Charts
- Paper Encounter Forms
- Referral/reports received from PCP by fax
- Collect co-pays at TOS
- Phone/website insurance verification (as time allowed)
- Dependent on Surgeons turning in coded encounter forms
- Batch, manual charge entry
- CBO Tasks through NextGen

Current Process
- One patient/One Chart (electronic)
- Electronic referrals WQ
- Care Everywhere
- Collect co-pays at TOS
- Real-Time Eligibility (RTE)
- Charge Capture at end of each Office Visit/Surgery
- Claim WQs
- Manual charge entry for non-BJC facilities once a week
- InBasket folder for CRM communications with CBO
- Consolidated statements across the Health System

Revenue Cycle Process

Prior to Appointment
- Live Staff members answer phones (including me sometimes) to schedule appointments
- If patient in system, verify demographics/insurance coverage, etc.
- If new patient, capture as much data as possible
- Run Real-Time Eligibility (RTE), inform patient of expected co-pay at TOS
- Steer patient to our website to download medical history forms or instruct to answer questionnaire in patient portal
- One to two days prior to appointment, staff member verifies what information still required; referral attached to chart or scanned
Revenue Cycle Process

Appointment
- Re-verify phone numbers (for surgery scheduler/hospital pre-admit staff)
- Scan photo ID and insurance cards
- Obtain electronic signatures, including for Care Everywhere access
- Scan medical history and medication lists, if needed
- Collect Co-pays ($50 for self-pay patients) and attempt to obtain self-pay outstanding balances (system-wide) or give patient CBO information to discuss financial assistance/payment plans

Surgery Scheduling
- Surgery scheduler obtains any pre-authorized/precertified for tests and surgeries mainly on-line or by phone/fax, if necessary

Charge Capture

Office Visits
- Surgeon selects LOS and any in-office procedures at end of appointment
- Charges go into either clean claims or coding review (or registration review) WQ
- I review for modifiers, correct coding & release for billing
- CBO has access to all notes/referrals/scanned media for appeals

Hospitals
- Consult/subsequent visits charge capture while rounding at BJC facilities through group patient list or through patient chart
- Surgeries at BJC facilities – either charge capture after surgery or after signing off on final OP note
- Staff member/surgery scheduler prepares consult/surgery paper encounter forms for non-BJC facilities
Reporting

Charge Capture
• Open Encounters Reconciliation
• OR Scheduled Surgery Case Reconciliation Report
• Hospital Note Charge Reconciliation Report

Productivity/AR
• Copay Collection past month
• Registration Verification Rate
• Referral Productivity
• Accounts Receivable by Payer
• Denials Summary
• Non Contractual write-offs
• Accounts Receivable Aging

My Dashboard
Continuing Education

ACMPE credit for medical practice executives............... 1.5
*AAPC Core A credit .............................................. 1.5
ACHE credit for medical practice executives.................. 1.5
CME *AMA PRA Category 1 Credits™* ...................... 1.5
CNE credit for continuing nurse education ................. 1.5
*CPE credit for certified public accountants (CPAs)........ 1.8
CEU credit for generic continuing education............... 1.5

Let the speakers know what you thought!
Evaluations will be emailed to you daily.

Thank You.

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Ste 205
St. Peters, MO 63376