Certified Revenue Cycle Representative

Coaching Course – Unit 1 Patient-Centric Revenue Cycle

Unit 1: Patient-Centric Revenue Cycle

1.1 Patient-Centric Revenue Cycle Overview

1.2 Healthcare Dollars and Sense

1.3 Patient Experience & Satisfaction

1.4 Collaboration & Continuum of Care

1.5 Compliance & HIPAA Regulations

1.6 Medicare Compliance & Regulations

1.7 Ethics

1.8 Volume to Value

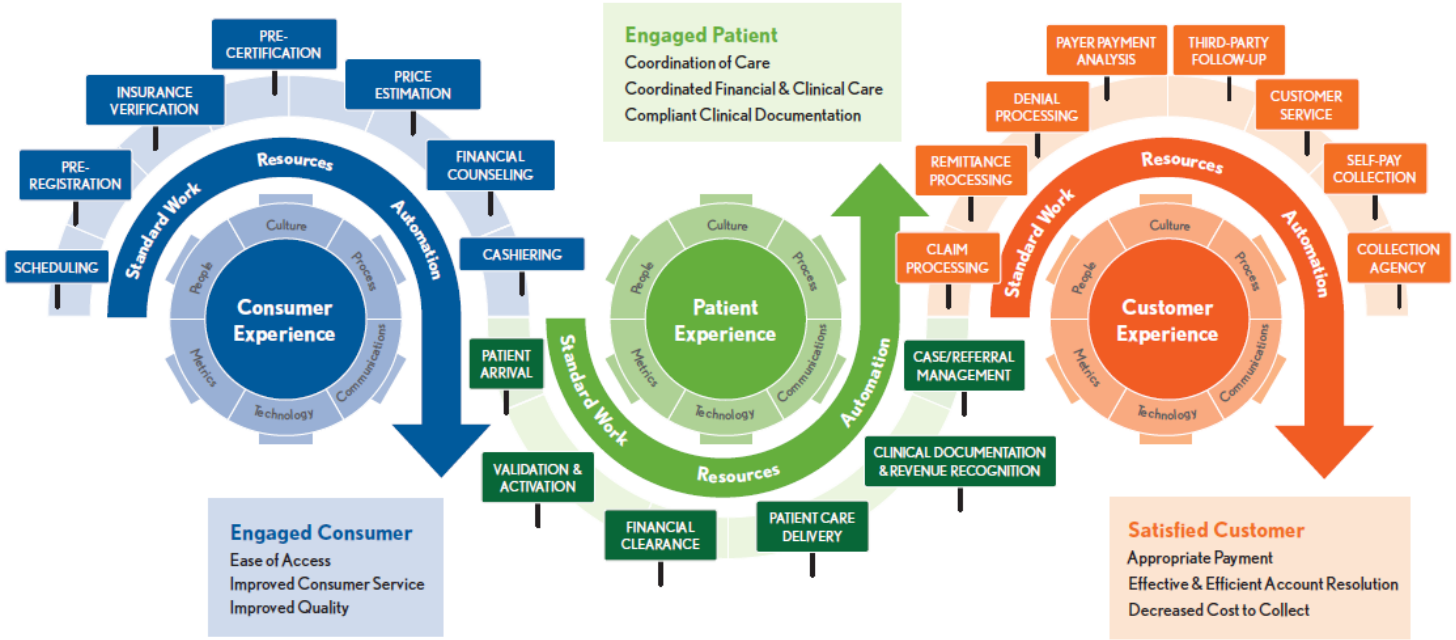
1.9 Financial Overview

1.10 Key Performance Indicators

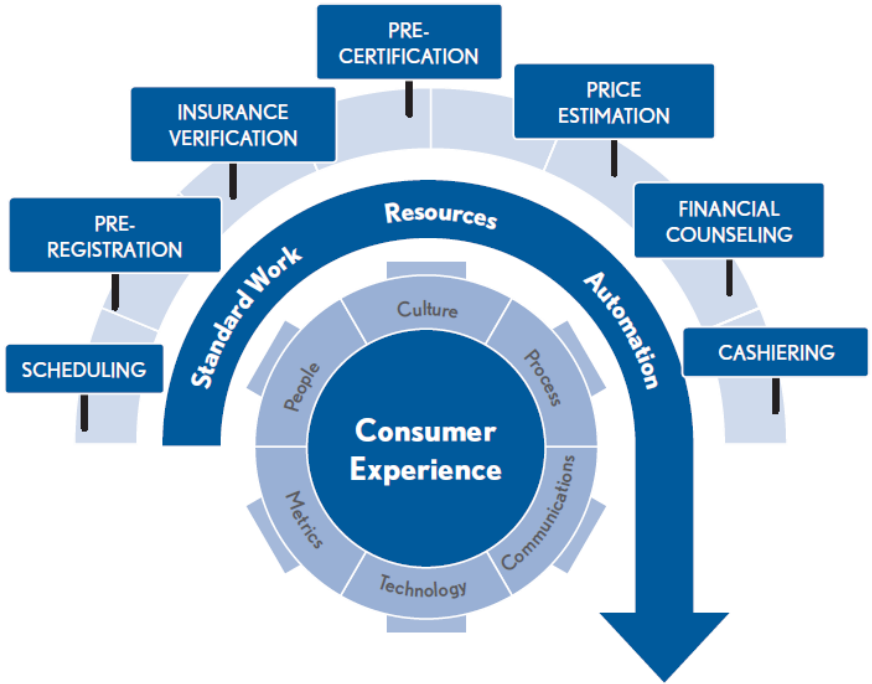
1.1: Patient-Centric Revenue Cycle Overview

- Identify the three critical segments in the revenue cycle.
- Identify the activities that occur in each segment of the revenue cycle.

The Contemporary Revenue Cycle



ENGAGING THE CONSUMER



Engaged Consumer

Ease of Access
Improved Consumer Service
Improved Quality

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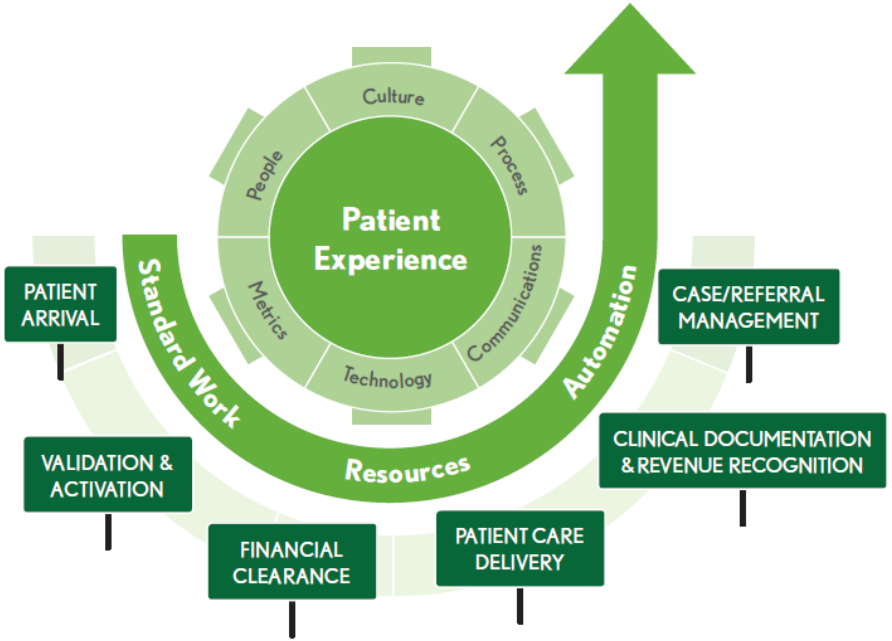
Engaging the Patient

Engaged Patient
Coordination of Care
Coordinated Financial & Clinical Care
Compliant Clinical Documentation



ENGAGING THE CUSTOMER

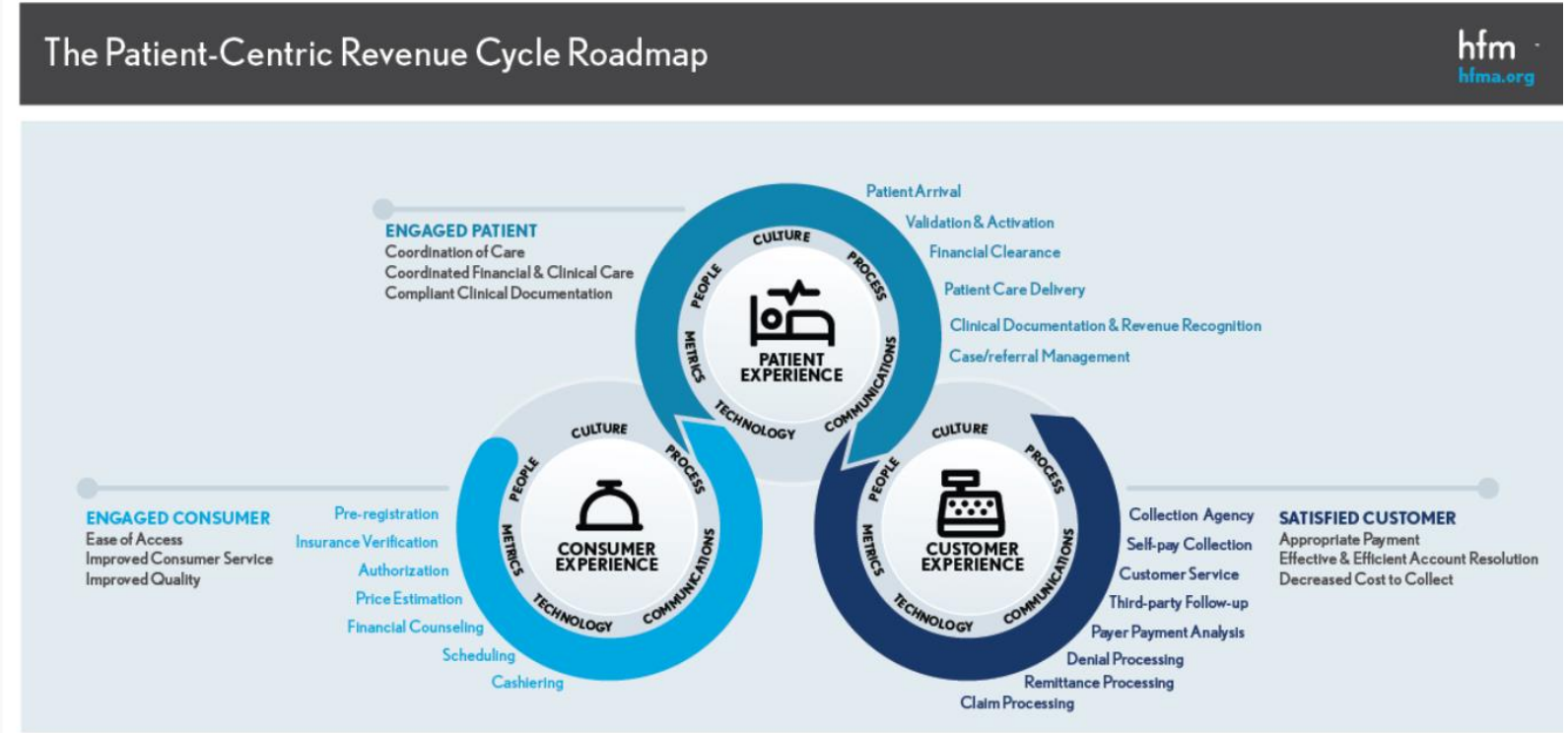
Satisfied Customer

Appropriate Payment

Effective & Efficient Account Resolution

Decreased Cost to Collect

Patient Centric Revenue Cycle

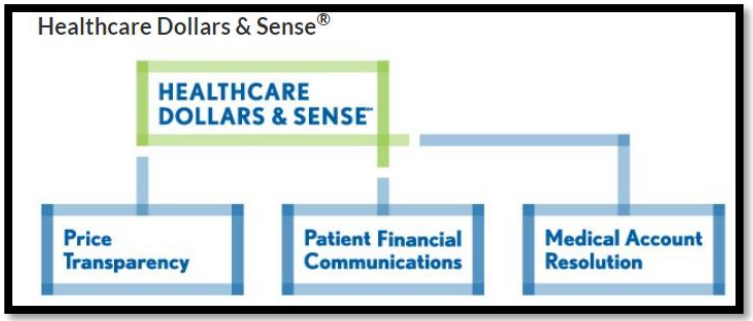


Key Points

- Three segments of the revenue cycle: pre-service, time-of-service, and post-service
- Pre-service is where scheduling and pre-access processing is completed.
- In time-of-service a final account review is completed, or registration and financial processing is completed for unscheduled patients.
- Account activities occur after is discharged in the post-service segment.

1.2: Healthcare Dollars and Sense

- Identify the purpose and critical components of the HFMA Dollars and Sense initiative.
- Identify the purpose and principles of:
  -patient financial communication best practices
  -price transparency
  -medical account resolution



Patient Financial Communications

- Consistency, clarity, transparency
- When and Where to Have Patient Financial Discussions
- Routine and Complex Scenarios
- Routine Activities
- The Provider-Patient Conversation

Price Transparency

- The Need for Pricing Transparency
- The Importance of Pricing Transparency
- Task Force Consensus

Medical Account Resolution

- Medical Account Resolution-Best Practices
- Concluding Medical Account Resolution-Best Practices

Key Points

- Healthcare Dollars and Sense is the name given to three HFMA revenue cycle initiatives:
  -Patient Financial Communications
  -Price Transparency
  -Medical Account Resolution
- Communication and sharing information with patients support higher levels of patient satisfaction.

Questions?

1.3: Patient Experience and Satisfaction

- Identify patients' expectations related to the revenue cycle, the HCAHPS survey and the impact of communication and customer service to patient experience and satisfaction.
- Recognize the strategies used by revenue cycle leadership and staff in improving overall patient experiences.
- Identify the hard and soft costs to the provider of poor quality patient experiences.

Today's Patients as Consumers

- Patient Satisfaction Metric within Industry (HCAHPS)
- CMS
- HCAHPS Survey

Revenue Cycle Team Members Role in Patient Satisfaction

- Impact of Communication and Customer Service
  -Implement
  -Educate
  -Communicate
- Treat that patient as you would wish to be treated.

Cost of Poor Quality Patient Experiences

- Hard – loss of revenue
- Soft – negative experience passed on in various ways and to various audiences
- Quality also has an impact in billing, physician and case management

Impacts to Providers

- Billing
- Physician
- Case Management
- Legal Issues

Key Points

- Patients are consumers with expectations
- Patients want easy patient access and scheduling processes, and expect efficient and well-trained revenue cycle personnel
- Expanding to a value-based payment model increases the need to satisfy patients' expectations
- Make the focus on clear communication, customer service, and quality

1.4: Collaboration and Continuum of Care

- Identify how information technology, clinical services, finance and health plan contracting work within the revenue cycle.
- Identify programs and services that are part of the continuum of care.

Collaboration with Information Technology

- **Collaboration with Information Technology**
  - Healthcare providers today are faced with an increasingly complex operating environment. IT provides a competitive advantage in several areas, including:
  - Streamlining operations
  - Increasing productivity
  - Assessing profitability by health plan and patient type
  - Providing quality care
- **Organizations that do not keep up with information technology may be faced with limitations on their ability to attract and retain patients.**

Continuum of Care

- Working Together
- Philosophy
- Coordination of Patient Care
- Providers include:

  -Physician
  -Skilled Nursing Facility
  -Home Health Agency
  -Durable Medical Equipment
  -Hospice
  -Assisted Living

Key Points

- Information Technology enables healthcare providers to enhance patient experiences through efficient scheduling, tracking and reporting
- Clinical Services prepare for and serve the patient, as well as confirm the accuracy of the patient's information in a timely manner
- Finance provides analysis and reporting to ensure compliance

Key Points

- Continuum of care is a way of coordinating and linking healthcare resources to avoid duplication, thus facilitating a seamless movement among care settings
- Continuum of care involves healthcare professionals in multiple settings at multiple levels working together with the overall goal of coordinating patients' healthcare

1.5: Compliance & HIPAA Regulations

- Identify the purpose of essential elements in a corporate compliance program.
- Identify the purpose and elements of an Office of the Inspector General (OIG) work plan.
- Identify the purpose and elements of HIPAA.

Introduction to Compliance

- Guidance Documents
- Essential Elements
- Compliance Planning

Compliance Programs

Key risk areas that can lead to potential fraud and abuse for hospitals and providers include:

- Upcoding of MS-DRG assignments
- Inaccurate or incorrect coding
- Bundling/unbundling of services
- Duplicate billing
- Billing for medically unnecessary services
- Waiving of deductibles to entice business
- Insufficient documentation

Compliance Program Elements

- Regular, comprehensive training
- “Hotlines” or other means of receiving anonymous communications about compliance issues
- Mechanisms for monitoring compliance, including independent evaluations
- Communicating standards and procedures internally

Compliance Program Elements

- Self-reporting of adverse administrative events
- A corporate culture that encourages the constructive identification of potential or actual violations
- Full support by the entire organization
- Oversight of personnel by high-level personnel
- Written policies and procedures, including an employee code of ethics

Code of Conduct

- Areas of Focus:
  -Human resources
  -Privacy/confidentiality
  -Quality of care
  -Billing/coding
  -Conflicts of interest
  -Laws/regulation
- Benefits of the Code of Conduct
- Role of the Chief Compliance Officer (CCO)

Office of the Inspector General

- Identifies opportunities to improve programs and holds accountable those who do not meet federal standards
- Publishes an annual work plan with specific tasks
- Violations of the OIG Work Plan result in issuance of Corporate Integrity Agreements

HIPAA

- Health Insurance Portability and Accountability Act (HIPAA) Goals
- Expand health coverage by improving the portability and continuity of health insurance coverage in group and individual markets
- Give patients access to their health files and the rights to request amendments or make corrections
- Facilitate electronic exchange of medical information

Transaction Sets

- The final rule on transactions standardized the electronic formats so that data, remittance advice, and claims information could be transmitted using one type of electronic format

Transaction Sets

Transaction/Code Set Name	ID Number
• Healthcare claim transactions	837
• Enrollment and disenrollment in a health plan	834
• Healthcare benefit/eligibility inquiry and response	270/271
• Healthcare claim payment and remittance advice	835
• Health plan premium payments	820
• Health claim status request and response	276/277
• Referral certification and authorization	277/278
• Claim	837

Standard Unique Employer Identifier

- The use of a unique employer identifier is required under HIPAA. The rule adopts the employer identification number assigned by the IRS to be used in standard transactions to identify the employer of an individual described in a transaction, such as the transmission of enrollment information to a health plan.

National Provider Identifier (NPI)

- The NPI is a unique identification number for covered healthcare providers.
- NPIs are used in the administrative and financial transactions adopted under HIPAA.

Privacy of Health Information

- Define protected health information and access thereto by individuals, payers, and business associates -- provide training
- Ensure that training is based on the job responsibilities of staff who handle protected health information.
- Ensure that a privacy officer is hired/designated
- Ensure that a contact person is hired/designated to handle questions or concerns regarding the protection of personal health information

Security of Health Information

- HIPAA specifies a series of administrative, technical, and physical security procedures for covered entities to use to ensure the confidentiality of electronic protected health information.

Key Points

- Compliance plan required
- Revenue Cycle staff are required to understand the importance of compliance, especially Medicare rules
- HIPAA requires privacy and security of information and use of electronic transaction standards

Questions?

1.6: Medicare Compliance & Regulations

- Identify Medicare compliance issues specific to the patient-centric revenue cycle.
- Identify coding issues specific to the patient-centric revenue cycle.

DRG Window

Known as the “Three-Day Rule”

Basics to keep in mind:

- Non-diagnostic outpatient serves
- Diagnostic services provided
- Defining “three days”

Specific Medicare Compliance Issues

Medicare as Secondary Payer (MSP)

- Medicare, from the beginning, has required payers in certain defined situations to pay the entire claim
- MSP requirements are clearly defined as well

MSP Situations

- Working aged
- Accident or other liability
- Disability
- End-Stage Renal Disease (ESRD)

Medical Necessity Screening and ABNs

Medicare program pays only for **medically necessary** services

- Providers are expected to screen services for compliance with Medicare coverage rules
- Advanced Beneficiary Notice (ABN)

ABN Requirements

- Wording
- Specificity
- Determining information
- Timeliness
- Understandable
- Comply with CMS form

The Two- Midnight Rule

CCI, Modifiers, and CPT/Revenue Code Issues

- Centers for Medicare and Medicaid Services (CMS) developed the Correct Coding Initiative (CCI)
- The purpose of the CCI is to ensure that the most comprehensive groups of codes, rather than the component parts, are billed.

Key Points

- Medicare DRG Three-Day Window Rule focuses on certain outpatient services to be billed as part of an inpatient stay
- The ABN informs a Medicare beneficiary before receiving specified items or services regarding payment status
- Medicare acts as a secondary payer in certain situations
- Correct Coding Initiative (CCI) developed by Centers for Medicare and Medicaid (CMS)

1.7: Ethics

- Define business or organizational ethics.
- Identify the resources used to guide the application of ethics.
- Identify ethics issues or violations as they pertain to the revenue cycle.

Ethics

- Why talk about it?
- What to talk about?
  -Health Care Complexity
  -Resources to Review
  -Ethics Issue Awareness
  -Interpretation of Ethical Behavior

Ethics Violations Examples

- Financial misconduct
- Overcharging
- Theft of property
- Falsifying records to boost reimbursement
- Miscoding claims
- Privacy violations

HIPAA

- Examples:
- Using Personal email account with patient information
- Access EHR for valid reasons
- Cannot review your own record or family

Key Points

- Ethical behavior is important, especially in health care
- Ethical standards are hoped for and expected by staff and management in health care
- It is important for staff and management to uphold the business ethics of the provider and act as peer role models

Questions?

1.8: Volume to Value

- Recognize the major provisions of the Affordable Care Act.
- Identify the purpose of an Accountable Care Organization (ACO) and current types being tested.
- Identify the purpose and participants of the Standard Quality Measures.

Overview of the Affordable Care Act

- The Patient Protection and Affordable Care Act, also known as the Affordable Care Act or ACA, was passed and signed into law in 2010. It was designed to reform the healthcare system into a system that rewards greater value, improves the quality of care and increases efficiency in the delivery of services.

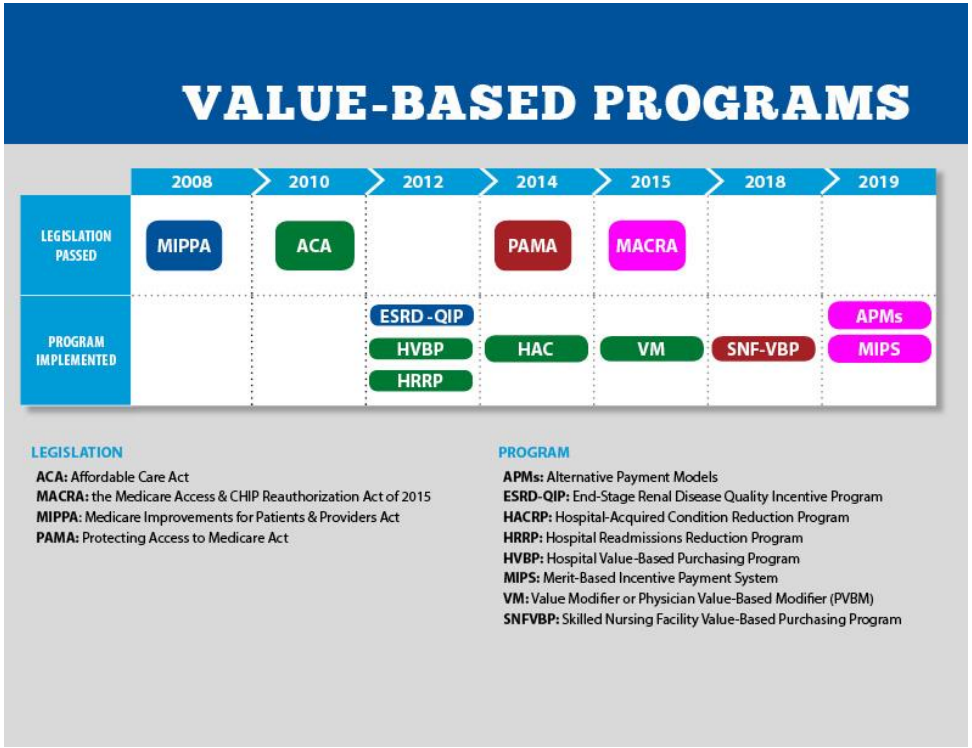
ACA Provisions

- Improving the quality of care is one of the major cost containment provisions of the Act.
- Another cost containment provision of the act is reforming the healthcare delivery system.
- The Act also has the goal of encouraging price transparency and modernized financing systems.
- Addressing waste, fraud, and abuse is another goal of the ACA.

Improving Quality of Care

- Quality of care improvements include:
  - Reducing hospital readmissions.
  - Reducing hospital acquired conditions.
  - Comprehensive Joint Replacement and Cardiac Services
  - Improving physician quality reporting.

Reforming the Delivery System



Center for Medicaid Innovation

ACO Types

- Medicare Shared Savings Program
- Next Gen ACO
- Investment Model ACO
- Comprehensive ESRD Care Model

Volume to Value

- Other Non-demonstration Pay-for-Performance Programs
  -Hospital Value Based Purchasing
  -Hospital Readmission Reduction Program
  -Physician Quality Reporting
- Episode Based Payment Initiatives
  -Bundled Payments for Care Improvement (BPCI)
  -Comprehensive Care for Joint Replacement

Medicare's Pay-for-Performance Initiatives

- Standardized Quality Measures
  -Critical component of CMS initiatives
  -Promote systemic adherence to quality goals that include effective, safe, efficient, patient-centered, equitable and timely health care
  -Variety of stakeholders worked to develop the Standardized Quality Measures

Key Points

- An ACO is a delivery system of physicians, hospitals and other healthcare providers to manage and coordinate the care of a patient population.
- The ACA was designed to reform the healthcare system into one that rewards greater value, improves the quality of care and increases efficiency in the delivery of services
- CMS has set a target of moving Medicare payments from volume-based to value-based payments and increasing the types of alternative payment models which include value-based payments
- Quality is an integrated part of the changes involved in the volume to value initiatives

Questions?

1.9: Financial Overview

- Identify the basic components on a healthcare provider's financial reports.
- Recognize the difference between terms gross accounts receivable (A/R) and net A/R.
- Identify the concepts related to establishing "reserves" for contractual allowances, bad debts, and charity, and determine how they are presented on financial statements.

Financial Reports

- Income Statement
  -Revenue
  -Expenses
  -Profits
- Balance Sheet
  -Asset
  -Liabilities
  -Equity
- Cash Flow Statement
  -Operation
  -Investment
  -Financing

Accounting Methods

- **Accrual**: Revenue recorded when it is earned to permit the alignment of revenue with associated expenses.
- **Cash**: Revenue recorded when payment received.
- **Fund**: Record-keeping method to manage categories of net assets to ensure compliance with the restrictions on those funds.

Gross and New Revenue

- **Gross Revenue**: Total charges entered for all patients for the services they received.
- **New Revenue**: Estimate the dollar amount of contractual, discount, or other allowances against gross revenue.

Gross and Net Revenue

- Estimating Net Receivables
- Reserve Amounts on a Provider's Financial Statement
  -Contractual Allowances
  -Bad Debts
  -Charity Care
- Importance of Calculating Reserves
- Contra-Account Amounts

Bad Debt vs. Charity Care

Key Points

- To determine gross revenue, the charges for all the services that patient has received is totaled.
- To determine net revenue, financial services estimate the dollar amount of contractual, discount or other allowances that will be applied against those revenues.
- Reserve amounts are reported on the provider's financial statement as Contractual Allowances, Bad Debts, and Charity Care.

1.10: Key Performance Indicators

- Identify the purpose of Key Performance Indicators (KPIs).
- Identify the components of an accounts receivable (A/R) aging analysis.
- Identify the calculation used to determine the days of revenue in A/R.

HFMA MAP Keys

Key Performance Indicators (KPIs)

Section	ID Number	Key Name
Patient Access	PA-1	Pre-registration Rate
	PA-2	Insurance Verification Rate
	PA-3	Service Authorization Rate-Inpatient & Observation
	PA-4	Service Authorization Rate-Outpatient
	PA-5	Conversion Rate of Uninsured Patient to Payer Source
	PA-6	Point of Service Cash Collections
Pre-Billing	PB-1	Days in Discharged Not Final Billed
	PB-2	Days in Final Billed Not Submitted to Payer
	PB-3	Days in Total Discharged Not submitted to Payer
Claims	CL-1	UB04 (837-I) Clean Claim Rate
	CL-2	Late Charges as Percentage of Total Charges
Account Resolution	AR-1	Aged A/R as Percentage of Billed A/R
	AR-2	Aged A/R as Percentage of Billed A/R by Payer Group
	AR-3	Denial Rate (Zero Pay and Partial Pay Denials)
	AR-4	Denial Write-offs as Percentage of Net Patient Service Revenue
	AR-5	Bad Debt
	AR-6	Charity
	AR-7	Net Days in Credit Balances
Financial Management	FM-1	Net Days in Accounts Receivable
	FM-2	Cash Collected as Percentage of Net Patient Service Revenue
	FM-3	Uninsured Discount
	FM-4	Uncompensated Care
	FM-5	Case Mix Index
	FM-6	Cost to Collect
	FM-7	Cost to Collect by Functional Area

General KPIs

- Days of Revenue in Receivables
- A/R Aging Analysis
- Discharged Not Final Billed

General KPIs

- Cost to Collect
- Cash Collected as Percent of Net Revenue
- Denials as a Percent of Net Revenue
- Credit Balances – Days Outstanding

Key Concept Slide

- Key Performance Indicators (KPIs) set standards for accounts receivables (A/R) and provide a method of measuring the collection and control of A/R.
- Days in A/R is calculated based on the value of the total accounts receivable on a specific date.
- A/R day calculations can also be done for specific payers to evaluate the collection efficiency and payment progress on third-party payers or self-pay patients.
- Completing an analysis of A/R aging and KPIs can help identify issues and areas for improvement

Questions?

HFMA Texas Chapters

Webinar Series

CRCR Certification Course – Session 2

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Unit 2: Pre-Service – Financial Care

2.1 Types of Patients

2.2 Scheduling

2.3 Pre-Registration

2.4 Health Plans

2.5 Health Plans – Managed Care

2.6 Price Transparency

2.7 Patient Financial Communication

Thank You!

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APPENDIX

What happens during the post service stage?

- Orders are entered, results are reported, charges are generated, and diagnostic and procedural coding is initiated
- The encounter record is generated and the patient and guarantor information is obtained and/our updated as required.
- Final coding of all services, preparation of claims, payment processing and balance billing and resolution.
- The focus is on the patients and his/her financial care, in addition to the clinical care provided for the patient.

CMS Price Transparency Mandate

No Surprises Act

Which option is not a main HFMA Healthcare Dollars and Sense Revenue Cycle Initiative?

- Patient Financial Communications
- Process Compliance
- Medical Account Resolution
- Price Transparency

Which items are not best practice?

- Educate patients
- Report to healthcare plans when patient account is transferred to collection agency.
- Follow best practices for communication.
- Exercise moderate judgement when communicating with providers about scheduled services.
- Coordinate to avoid duplicative patient contacts.

What is the objective of the HCAHPS Initiative?

- To provide a standardized method for evaluating patients perspective on hospital care.
- To make certain that during registration, key information is verified by means of a picture ID and an insurance care.
- To conduct evaluations concerning patients' perspective on hospital care.
- To provide clear communication and good customer service, which will give the provider a competitive edge.

Which is not a department that supports and collaborates with the revenue cycle?

- Clinical Services
- Finance
- Assisted Living
- Information technology

Which of the following are not essential elements of a compliance program?

- Reasonable methods to achieve compliance
- Established compliance standard and procedures
- Automatic dismissal of any employee excluded from participation the federal healthcare program
- Oversight by high level personnel
- Designation of a compliance officer employed within the Billing Department

Which option is not a continuum of care provider?

- Hospice
- Health Plan Contracting
- Physician
- Skilled Nursing Facility

Identify which option is not a work plan task mentioned in this course.

- Reconciliation of Outlier Payments
- Denials and Appeals in Medicare Part C
- Medicare Payments made outside of the hospice benefit.
- Denials and appeals in Medicare Part D.

In order to promote correct coding, CMS developed what?

A. The correct coding initiative (CCI)

B. The Advance Beneficiary Notice of Noncoverage (ABN)

C. The Medicare Secondary Payer (MSP)

D. Modifiers

What do business/organizational ethics represent?

A. Principles and standards by which organizations operate

B. A healthcare providers practices and principles

C. An employees actions influenced by experiences and value system

D. The patient privacy standard within healthcare.

Which of these statements describes the new methodology for NPR?

A. Net patient service revenue is defined as the average payment amount for the payer but not recorded until the end of the month processing is completed.

B. Gross patient service revenue is recorded as net patient service revenue until such time as all payments are received.

C. Net patient service revenue is defined as the total incurred charges, less the explicit price concession, less any applicable implicit price concession(s) as applied to the specific portfolio of accounts.

D. Net patient service revenue is gross revenue minus any contractual adjustments applicable to the account. Any additional adjustments are not recorded until the account reaches a zero balance.

E. Net patient service revenue is the sum of the balances of all charges and payments recorded in the accounting period.

What is the intended outcome of collaborations made through an ACO?

A. To ensure appropriateness of care, elimination of duplicative services, and prevention of medical errors.

B. To create cost-containment provisions to reform the healthcare delivery system.

C. To reform the healthcare system into a system that rewards greater value, improves the quality of care and increases efficiency in the delivery of services

D. To provide financial incentives to physicians for reporting quality data to CMS.

What are KPI's?

A. Benchmarks which are used to compare Key Performance Indicators in an organization to an agreed upon average or expected standard within the same industry.

B. Key performance indicators, which set standards for accounts receivable (A/R) and provide a method of measuring the collection and control of A/R.

C. Days in A/R is calculated based on the value of the total accounts receivable on a specific date.

D. A component that can divide the accounts receivable into 30, 60, 90, 120 days, and over 120 days categories, based on the date of service/discharge