Healthcare Financial Management Association

Certified Revenue Cycle Representative (CRCR)
Key Concepts Guide

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Certified Revenue Cycle Representative (CRCR) Key Concepts Guide
Supplement to HFMA's Online CRCR Program

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1. Introduction – Key Concepts Approach and Focus

HFMA's Certified Revenue Cycle Representative (CRCR) program is an online, self-directed, interactive program that provides a comprehensive overview of best practice revenue cycle approaches. It offers you the opportunity to expand your knowledge of contemporary revenue cycle issues and serves as part of a career ladder for your ongoing professional development. By becoming a CRCR, you, your team, and colleagues attain the designation that proves a high level of current health care revenue cycle knowledge and expertise.

This document embodies a "key concepts" approach, which presumes that you have a basic understanding of the revenue cycle and how it influences the financial outcomes of a healthcare organization.

This guide is intended for those who wish to make focused notes and capture important concepts while working with the online study materials. Taking the time to use and/or customize the guide can help you to develop a handy review tool. The concept guide identifies important ideas and is a supplement to the online study program. It is not a replacement for the online materials nor a summary of the online course. It is intended to help you summarize your personal learning.

Before You Start

Please note that there are four distinct units within the online program, and there are review questions throughout those units in the online material. Those questions are separate and distinct from the exam, or assessment, that covers content from all four units.

Working through this concept guide will not, in and of itself, prepare you to sit for the CRCR certification assessment. Review of the online material is important as assessment questions do tie back to the content presented.

Upon successful completion of the assessment, you will be recognized as a Certified Revenue Cycle Representative (CRCR). To help guide you in your studies, we have also included the exam content outline on the next page.

Best wishes on taking this next step in your professional development through HFMA's CRCR program.

CRCR Content Outline & Areas of Exam

Subject Area	Topics	Weight in Exam
Patient Centric Revenue Cycle Unit One (1)	1.1 Revenue Cycle Overview 1.2 Health Care Dollars & 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 Payment Models 1.9 Healthcare Financial Reporting 1.10 Key Performance Indicators in the Revenue Cycle	30%
Pre Service Financial Care Unit Two (2)	2.1 Types of Patients 2.2 Scheduling 2.3 Pre-Registration & Insurance Verification 2.4 Health Plans - An Overview 2.5 Health Plans - Managed Care 2.6 Price Transparency - NSA 2.7 Patient Financial Communication	22%
Point of Service Financial Care Unit Three (3)	3.1 Patient Arrival & Intake 3.2 Case Management 3.3 Revenue Capture & Recognition 3.4 Health Information Management (HIM) & Coding 3.5 Claim Form Requirements, Edits & Electronic Data Interchange (EDI) 3.6 Basic Billing Rules & Payment Methodologies 3.6a COVID-19 Regulatory & Practice Changes 3.7 Health Plan Contracts	23%
Post Service Financial Care Unit Four (4)	4.1 Cash Posting, Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) 4.2 Credit Balances 4.3 Exception Based Processing – Denied Claim 4.4 Exception Based Processing - Non-Paid 4.5 Self-Pay Follow Up 4.6 IRS Regulation Section 501(r) 4.7 Patient Debt Regulations 4.8 Medical Account Resolution 4.9 Outsourcing	25%

Unit One: The Patient-Centric Revenue Cycle

1.1 Revenue Cycle Overview

The Patient-Centric Revenue Cycle
The Revenue Cycle includes all of the major processing steps required to process a patient account from the request for service through closing the account with a zero balance and purging it from the system.

Pre-Service

Time-of-Service

Post-Service

1.2 HFMA's Healthcare Dollars and Sense

Healthcare Dollars and Sense is the name given to three HFMA revenue cycle initiatives:

Patient financial communications best practices

Best practices for price transparency

Medical account resolution

Financial counseling

If appropriate, the patient may be referred to a financial counselor and/or offered information regarding the provider's financial counseling services and assistance policies. Providers should have a widely publicized toll-free number for patients to call to receive assistance in financial matters and address any concerns they may have.

Patient share

Prior Balances

Balance resolution

Price Transparency

Pricing transparency has evolved based on providers' need to easily provide pricing information to patients. The Affordable Care Act legislated the development of a Health Insurance Marketplace, also known as Health Insurance Exchange, where individuals and small businesses can compare and purchase qualified health benefit plans.

The Need for Pricing Transparency

As part of these consumer driven programs, patients need pricing information to make informed health care decisions.

- Price Transparency in Health Care

- Understanding Healthcare Prices: A Consumer Guide

Medical Account Resolution

HFMA partnered with ACA – not the Affordable Care Act – the Association of Credit and Collections Professionals International – and brought together provider organizations, our business partners in the collection agencies, and patient advocates to form the medical debt task force. This group developed a best practice workflow that builds off of HFMA's previous Patient-Friendly Billing ® work and spans the patient-centric revenue cycle. The goal was to improve both the efficiency of the revenue cycle and the patient experience.

Medical Account Resolution — Best Practices

Educate

Bills

Policies

Consistency

Coordinate

Judgment

Timing

Report and Track

Concluding Medical Account Resolution — Best Practices

Implementing these best practices involves close coordination with all early out and/or collection agencies to ensure that the appropriate screening for coverage and/or financial assistance eligibility occurs at each point in the account resolution process.

1.3 Patient Experience and Satisfaction

Patient Satisfaction Metric within the Industry (HCAHPS)

The Center for Medicare and Medicaid Services (CMS) implementation of the value-based purchasing program has increasingly highlighted a focus on core measures, one of which is the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) initiative.

The objective of the HCAHPS initiative is to provide a standardized method for evaluating patients' perspective on hospital care.

HCAHPS Survey
Many of the 27 questions on the HCAHPS survey are related to clinical care and patient engagement; however, one question encompasses the entire patient experience, including registration, billing, collection and other revenue cycle activities. This question is as follows:

“Would you recommend this hospital to your friends and family?”

Revenue Cycle Team Members Role in Patient Satisfaction

It is important to go the extra mile by creating patient-friendly processes aimed at improving the overall patient experience.

Improving the overall patient experience requires revenue cycle leadership and staff to simultaneously be inquisitive, responsive, innovative and flexible. Leadership and staff must always remember the following points.

Implement

Educate

.
Communicate

Impact of Communication and Customer Service Revenue cycle team members play a critical role in retaining patients as customers. Recognizing this fact, staff should provide clear communication and good customer service, which will give the provider a competitive edge. A key element to clear revenue cycle communication is helping patients and families understand their financial responsibilities for care, and what services or programs are available to help them if needed. The paramount customer service guideline is to treat the patient as you would wish to be treated.

Cost of Poor Quality Patient Experiences

The cost of dissatisfied customers can be summarized in terms of hard and soft costs. Hard

Soft

Quality

Nearly 40% of billing information is obtained during the registration process (access service).

When the data is missing or inaccurate, delayed payment or nonpayment for services occurs thus impacting the patient's experience.

Quality: Billing Communication

Within this area, revenue cycle activities for improving communication and customer service include:

- Modifying billing formats and statements for easier patient comprehension.
- Extending normal business hours for patient inquiries and complaints.
- Making sure that all staff answers the telephone courteously and gives the customer his/her name for future reference.
- Resolving questions or complaints without transferring the customer to another person whenever possible.
- Following up on all customer inquiries or complaints within 48 hours.
- Including customer service responsibilities in every staff member's performance plan and holding staff accountable during performance reviews.

Payments are negatively affected if appropriate authorization information is not provided on the claim. This missing information may be discovered during final pre-bill editing. To rectify this issue, missing information should be retrieved and entered into the claim or the claim can just be submitted with missing or incorrect information, thus passing the responsibility on to another department. In either case, valuable time is spent retrieving the correct or missing information before submitting or resubmitting the claim.

Rework

Physician Impacts

Physician Identification

Patient Identification

Billing Information

Many physicians, especially hospital-based physicians, use the hospital's registration record to complete their billing. If patient information is incomplete or missing, it affects physicians' billing costs.

Service Delays

1.4 Collaboration and Continuum of Care

Collaboration with Information Technology

Healthcare providers today are faced with an increasingly complex operating environment. Information technology provides a competitive advantage in several areas, including:

Streamlining operations

increasing productivity

Assessing profitability by health plan and patient type

Providing quality care

Information Technology: Software Applications

Many functions within the healthcare revenue cycle are (or can be) streamlined through automation.

Let us look at the various functions within the revenue cycle that may benefit from outsourcing.

Appointment and resource scheduling:

- Admit, discharge, and transfer system (ADT) – Registration.

Patient account systems:

- Pre-bill editing
- Electronic claim generation – insurance and patient billing
- Payment tracking and automated follow-up queues
- Accounts receivable
- Cash posting
- Denials management
- Refund processing
- Collection account transfers

Additional Software May Include:

- Contract management
- Decision support
- Quality assurance
- Chart tracking
- Transcription
- Order entry
- Bed management
- Document imaging
- Electronic health record
- Online interfaces to health plan's enrollment eligibility screens
- Online access to health plan's benefit screens

- Referral authorization
- Utilization and productivity management
- Radiology clinical systems
- Laboratory clinical systems
- Pharmacy clinical systems
- Case mix and decision support

Information Technology: Emerging Technology

Revenue cycle managers must continually research new technologies to maintain operating efficiencies necessary to compete in today's evolving environment.

Online Patient Services

Identification Systems

Collaboration with Clinical Services

Collaboration with Finance

Collaboration with Health Plan Contracting

Continuum of Care Provider

Physician

Skilled Nursing Facility

Home Health Agency

Durable Medical Equipment

Hospice

Assisted Living

Continuum of Care Provider

- Physician

1.5 Compliance & HIPAA Regulations
Essential Elements in a Corporate Compliance Program

The burden of proof is generally on the healthcare facility; therefore, it is imperative to:

- Have a Plan.
- Follow the Plan.
- The Plan is a Corporate Compliance Program.
- Know What Happens if You Do not Follow the Plan.

Review the Code of Conduct to Verify You Follow the Plan.

- Chief Compliance Officer Role Oversees Code of Conduct.
- Know the Benefits of the Code of Conduct.
- The code of conduct represents the organization's compliance program as well as the organization's culture.

Corporate Compliance Program Elements

Element 1 –

Element 2 –

Element 3 –

Element 4 –

Element 5 –

Element 6 –

Element 7 –

Element 8 –

Element 9 –

Element 10 –

Element 11 –

Element 12 –

Element 13 –

Element 14 –

Element 15 –

Element 16 –

Code of Conduct

Area of Focus of Code of Conduct

- Human resources
- Privacy/confidentiality
- Quality of care
- Billing/coding
- Conflicts of interest
- Laws/regulation

The Office of inspector General

The Office of Inspector General (OIG) was created to protect the integrity of the Health and Human Services (HHS) Department programs and operations and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse.

OIG Responsibilities

2020 Work Plan Example 1

2020 Workplan Example 2

Violations of the OIG Work plan

Goals of HIPAA

HIPAA contains the following 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 right to request amendments or make corrections.

- Facilitate the electronic exchange of medical information with respect to financial and administrative transactions carried out by health plans, healthcare clearinghouses, and healthcare providers.

1.6 Medicare Compliance & Regulations

Medicare Compliance Rules
Medicare compliance rules include the following:

Violation of the DRG Window Rule

Medical Necessity Screening and ABNs

Advanced Beneficiary Notification Requirements

The Two-Midnight Rule

Medicare Secondary Payer (MSP)

Secondary Payer Situations:

Working Aged

Disability

End-Stage Renal Disease (ESRD)

Correct Coding Initiative:

Modifiers

Level I Modifiers

Level II Modifiers

1.7 Ethics

What To Talk About?

Law and Ethics

Healthcare Complexity

Resources to Review

Ethics Issue Awareness

Interpretation of Ethical Behavior

Ethics Violations Examples

Privacy Violation

1.8 Volume to Value Payment Models

Overview of the Affordable Care Act (ACA)

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. The ACA includes provisions to:

- Improve the quality of care.
- Reform the healthcare delivery system.
- Encourage pricing transparency and modernized financing systems.
- Address the issues of waste, fraud, and abuse.

Accountable Care Organizations

An Accountable Care Organization (ACO) is a delivery system of physicians, hospitals, and other healthcare providers, who work collaboratively to manage and coordinate the care of a patient population. The point of this collaboration is to ensure:

- Appropriateness of care;
- Elimination of duplicate services; and
- Prevention of medical errors for a population of patients.

Medicare Shared Savings Program

Next Gen ACO

Investment Model ACO

Comprehensive ESRD Care Model; comprehensive ESRD Care Model

Physician Quality Reporting

Hospital Value-Based Purchasing

Hospital Readmission Reduction Program

Bundle Payment for Care Improvement - BPCI

Model 1:

Model 2:

Model 3:

Model 4:

1.9 Healthcare Financial Reporting

Balance Sheet

This statement is a summary of the organization's wealth as of the date of the statement. It represents the summary of the organization's assets, liabilities and accumulated excesses from operations less any accumulated losses. Note that the net value of excesses and losses may be known as net assets.

Income Statement

This statement ties directly to the Balance Sheet and is the summary of the organization's revenues and expenses and any excess or loss from operations.

Cash Flow Statement

This statement is the summary of how cash was used and where it was obtained.

What is Gross Revenue?

What is Net Revenue?

Determining Net Revenue under ASC 606

Estimating Net Receivables

Bad Debts vs. Charity Care

1.10 Key Performance Indicators

Key Performance Indicators (KPIs) set standards for accounts receivables (A/R) and provide a method of measuring the collection and control of A/R. Benchmarking is used to compare KPIs in an organization to an agreed upon average, or expected standard, within the same industry.

HFMA's Map Keys

Importance of Benchmark

Techniques to Measure Accounts Receivables

Days of Revenue in Receivables

A/R Aging Analysis

Techniques to Measure Accounts Receivables

Credit balances — days outstanding

2.1 Types of Patients

Scheduled, Unscheduled, and Other Patient Types

Scheduled

Unscheduled: Outpatient, walk-in, emergent

Types of Patients — Scheduled

Non-Acute Types

Skilled Nursing

Hospice Care

Home Health Services

Durable Medical Equipment (DME)

Clinic

2.2 Scheduling

Scheduling:

Patient Information

Critical Patient Information

Patient Identification Information

Requested Service

Patient Instructions

Review and Validation

Information to Review

Order Requirements

ABN:

When is an ABN needed?

What Must Appear on the ABN?

2.3 Preregistration & Insurance Verification

The Pre-Registration Purpose and Process

Reasons for Pre-Registration

Benefits of Pre-Registration

Data Collection

MPI and Data Collection

2.4 Health Plans – An Overview

Many people under age 65 receive health insurance through an employer. Others buy their own insurance through the individual insurance market or the Insurance Marketplace (also known as insurance exchange) created by the Affordable Care Act. In addition, there are Federal and State health insurance programs available to qualifying individuals.

Medicare

Medicaid

TRICARE

Indian Health Service (IHS)

Blue Cross/Blue Shield

Managed Care Plans

Commercial Indemnity Plans

Self-Insured Plans

Liability claims
Medicare and Medicaid

Let us look at program features for Medicare and Medicaid.

Medicare

Medicaid

Medicare

The Medicare insurance program has features unique from other health plans. It is government sponsored and financed through taxes and general revenue funds.

Medicare Types

Medicare Part A Benefits

Medicare Part B Coverage

Medicare Claim Submission

Medicare Claim Status

Medicare Types

Medicare Part A

Medicare Part B

Medicare Part C

Medicare Part D

Medicaid

Eligibility Requirements

Other Health Plans

Apart from Medicare, Medicaid, and TRICARE, patients also opt for other health plans.

Indian Health Service

Blue Cross/Blue Shield

Managed Care Plans

Commercial Indemnity Plans

Self-Insured Plans

Liability Claims

2.5 Health Plans - Managed Care
Managed Care Plans

Health Maintenance Organization (HMO)

In-Network and Out-of-Network

Preferred Provider Organization (PPO)

Exclusive Provider Organization (EPO)

Point-of-Service Plan (POS)

Consumer Directed Health Plans (CDHP)

Medicare Advantage Plans

Medicaid HMO Plans

Specific Managed Care Requirements

Managed care health plans use prior authorizations and utilization management procedures to determine if care is medically necessary. The various tools and how they are used to manage utilization are listed below.

Pre-certification/pre-authorization

Referrals

Notification

Site-of-Service Limitations

Case Management

Discharge Planning

2.6 Price Transparency
What is Price Transparency?

The Elements of Determining a Price — Health Plan Information

2.7 Patient Financial Communications
Patient Financial Communications Best Practices

Patient Financial Communications Best Practices address patient communications regarding health plan coverage, financial counseling, financial responsibility for service, and unpaid balances and were developed by a task force of industry leaders.

Anticipating Charges and Determining the Patient's Financial Responsibility

Financial Assistance

Demographic

Income

Assets

Expenses

Negotiating Account Resolution

Payment Options

Full Payment

Short-term Payment

Bank Loan Program

Medicaid Eligibility Screening

Financial Assistance Program (FAP)

Time-of-Service Collections Steps

Unit Three Time of Service – Financial Care

3.1 Patient Arrival & Intake

EMTALA Requirements:

Emergency Department Registration

Registration for Unscheduled Patients – Emergency Department

Discharge Processing for Unscheduled Patients – Emergency Department

MPI and Data Collection:

Physician Identification

Registration systems allow for the documentation of several physicians who may be involved with a patient's care. Each physician type along with a description is listed below:

Primary Care Physician

Referring Physician

Attending Physician

Consulting Physician

Admission Orders

Types of Registration Forms

Consent to Treat

Conditions of Admission

Privacy Notice

Important Message from Medicare

Medicare Outpatient Observation Notice

Advance Directive/Medical Power of Attorney

Patient Bill of Rights

Bed Control

Bed Control: Assignment

Bed Control: Transfer Procedure

3.2 Case Management
Case Management Responsibilities

Types of Case Management Review

Case Management Responsibilities

Denials and Appeals

These appeals may include not only a letter explaining what the clinical documentation indicates about the patient's condition, but also a copy of relevant medical records. For more information on clinical denials, see course 4.3.

3.3 Revenue Capture & Recognition

Charge Capture

How Charges Are Recorded

Importance of Charges

What is the Charge master?

Core Elements of a Charge master

Click each button to see the typical data elements in a charge master.

Charge Description Master (CDM) Number

Department Number

Billing and/or Charge Description

Charge Amount

CPT/HCPCS Code

Modifiers

Revenue Codes

General Ledger (GL) Number

Charge master Challenges

Charge master Maintenance

HCPCS Codes

Modifiers are used with HCPCS codes to indicate that a procedure was altered by a circumstance but not changed in its definition or code. There are three levels of HCPCS modifiers.

Level I

Level II

Level III

HCPCS Modifiers

Level I Modifiers

Level II Modifiers

Level II Modifiers

Common Revenue Code, CPT Code, and Revenue Code Unit Issues

3.4 Health Information Management (HIM) & Coding

What is HIM?

Why is HIM Required?

Responsibilities of HIM

Importance of HIM

Important Activities of HIM

Electronic Health Record (EHR)

EHR System

EHR and Claim Generation

Coding and the Revenue Cycle

Finance

Senior Leadership

Patient Access

Patient Accounting/Billing

3.5 Claim Forms Requirements, Edits & Electronic Data Interchange (EDI)

Clean Claims

Prompt Payment

Patient Access Processing:

UB-04 Source of Data Summary

UB-04 Codes to Know

CSM 1500 Source of Data Summary

Compiled from Locator Data

3.6 Basic Billing Rules & Payment Methodologies

Common Billing Requirements:

Counting Inpatient Days

Outpatient Series

Time Limits for Billing

Provider Type Billing Rules

Rural Health Clinic

Hospice

Skilled Nursing Facility (SNF)

Ambulance Billing

Hospital-Based Physicians

Clinics

Telehealth

3.6a COVID-19 Regulatory & Practice Changes

Notes:

Learning Objectives

- Explain the basic billing rules for inpatient and outpatient billing of acute services in a variety of non-regular locations.

- Apply the cost-sharing rules for COVID-19 testing.

- Apply the temporary changes in telemedicine billing in effect during the COVID-19 emergency

3.7 Health Plan Contracts

All contracts include some type of "discounted" payment methodology. These discounted payment models can be as simple as a percentage discount to complex case rates with outliers. The most common payment models are:

- Per Diem Discount
- Per Diem Payment
- Diagnosis Related Group
- Ambulatory Payment Classification
- Fee Schedule

- Case Rates
- Package (Episodic) Pricing
- Bundled Payments (Medicare)
- Capitation

Silent PPOs
This refers to a scheme where health plans that do not offer preferred provider organization (PPO) policies apply contracted PPO discounted rates to patient's bills that are not part of the PPO network.

The Silent PPO works in the following way:
1

2

3

4

5

Knowledge of red -flags that signal potential silent -PPO activity include:

Unit Four Post-Service Financial Care

4.1 Cash Posting, Electronic Funds Transfer (EFT), & Electronic Remittance Advice (ERA)

Cash Handling Controls, Fraud, and Policies and Procedures

Fraud

Policies and procedures

Cash Posting Mail Receipt of Checks

Cash Receipts

Lock Box

Cash Posting: Payments Received at Registration, Reception or Another Location

Processing General Ledger Cash

4.2 Credit Balances

Credit Balances-Netted

Credit Balances-Liability

Reasons and Resolutions

Incorrectly posted allowances or incorrect payment estimates

Duplicate payments

Late charge credits processed after a claim is billed

The primary and secondary payers both paying as primary

Inaccurate upfront collections based on incorrect estimates of patient liability

Resolution Process

Small Credit Balances

4.3 Exception-Based Processing – Denied Claim

Claims Rejections

Types of Denials

Technical Denials

Clinical Denials

Underpayment Denials

Outpatient Reasons for Denial

Inpatient: Reasons for Denial

Denials in revenue cycle

Pre-service Denials

Time-of-service Denials

Post-service Denials

Recovery Audit Contractors

4.4 Exception-Based Processing – Non-Paid
Follow-up Work Flow - Open Third Party Balance

Insurance clean claim timeline

Fast forward 60 days

4.5 Self-Pay Follow-Up
Shifted liability

Effective Receivables Management

Priority

Reports

Tools used to Impact Payment Turnaround

Key Focus Areas

4.6 IRS Regulation Section 501(r)
ACA Legislation

The Affordable Care Act (ACA) legislation lays out requirements for:

- Community health needs assessments
- Policies related to financial assistance
- Emergency medical care
- Billing and collections activities

Compliance with ACA

Objective of ACA

Community Health Needs Assessment

Financial Assistance Policy

Extraordinary Collections Actions (ECAs)

4.7 Patient Debt Regulations

Title I—Truth in Lending Act

Regulation Z Information Disclosed

Title III— Restrictions on Garnishment

Title VI—Fair Credit Reporting Act

Title VIII — Fair Debt Collection Practices Act (FDCPA)

Bankruptcy

Types of Bankruptcy

Chapter 7: Straight bankruptcy

Chapter 11: Debtor reorganization

Chapter 13: Debtor rehabilitation

Telephone Consumer Protection Act

4.8 Medical Account Resolution

HFMA's Best Practices

Choice and Use of Collection Agencies

Selection of a Collection Agency

Evaluating a Collection Agency

Patient Relations

Agency Fees

Reports

Collection Results

4.9 Outsourcing

Outsourcing within the Revenue Cycle

Advantages of Outsourcing

Disadvantages of Outsourcing