A Team Approach: Profitability in the Revenue Cycle

July 24, 2018

IDPH Iowa Department of Public Health

Iowa Rural Hospital Learning Opportunity Program

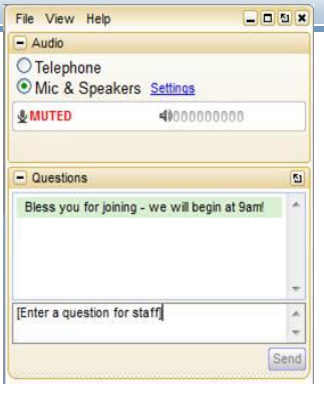
Provided by the Iowa Department of Public Health and HomeTown Health through the HRSA Critical Access Hospital FLEX Grant 2017-2018, Iowa Grant #5888CA04.

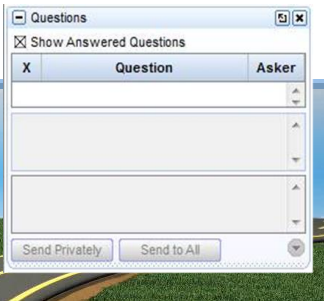
HOMETOWN HEALTH

Iowa Rural Hospital Learning Opportunity Program

Webinar Etiquette

- All attendees are in "Listen Only" mode
- Questions or comments?
  - Open "Questions" pane in dashboard.
  - Type in comments or questions.
  - Comments will be monitored throughout webinar.
  - Questions will be addressed at end of the webinar.





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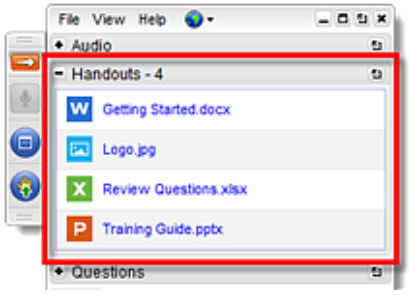
Webinar Resources

- This virtual meeting will be recorded and will be posted on the program dashboard for you to share with others on your team.
- Handouts are available for download in the handouts pane and will also be posted to the program dashboard.



Iowa Rural Hospital Learning Opportunity Program

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- Attend webinar/view recording in its entirety
- Pass online quiz with 80% or better.
- Complete webinar evaluation.

Following this webinar, all attendees who have attended this virtual meeting in its entirety will receive an email with a link to the quiz and evaluation.

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Iowa Rural Hospital Learning Opportunity Program

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- Georgia, Massachusetts and Ohio Board of Nursing
- Georgia Professional Standards Commission
- Human Resources Certification Institute (for their Professional in Human Resource Designation)
- National Association of Rehabilitation Professionals in the Private Sector
- National Association of Social Workers
- National Board for Certification in Occupational Therapy, Inc. (NBCOT)
- National Council for Therapeutic Recreation Certification
- National Registry of Emergency Medical Technology (EMT)
- National Registry of Microbiologists
- National Society of Professional Engineers
- Society for Human Resources Management
- State of Georgia, FL and Iowa Board of Professional Engineers
- The American Association of Integrative Medicine
- The American College of Forensic Examiners Institute
- The American Council on Pharmaceutical Education
- The American Psychotherapy Association
- The International College of The Behavioral Sciences
- The National Board for the Accreditation of Occupational Therapy (NBCOT)

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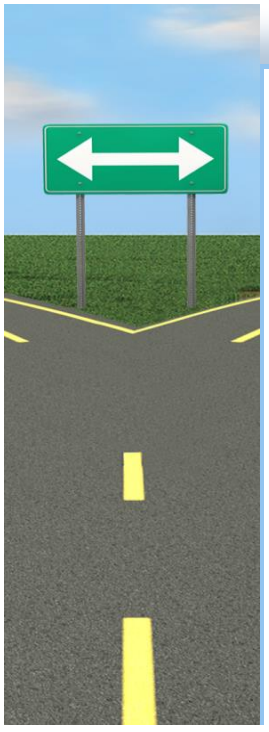
Group Participation

Are you on this broadcast with a group?

If so, please enter:
first/last names and email addresses
of those in attendance with you in the questions pane.



Regional Meeting

August 2, 2018
Arrowwood Resort and Conference Center
1405 Highway 71, Okoboji, IA 51355

Registration

http://www.hometownhealthonline.com/event/iowaworkshop2018/

2 Attendees FREE from each hospital
(additional at $125 per person)

Note: Hotel is not included in the grant for this workshop.
However, if you would like to come in early or stay over please contact Susan Wiese at susan.wiese@hometownhealthonline.com immediately!
Rooms are in demand and are available on a first come-first served basis.

Iowa Rural Hospital Learning Opportunity Program

Agenda

July 24, 2018

Welcome & Introductions	Stephanie Love - HTH
The Role of Patient Access and Upfront Collections	Sandy Sage, RN - HTH
5 MIN BREAK	
The True Impact of Denials	Sandy Sage, RN - HTH
Upcoming Events & Resources	Stephanie Love - HTH

Disclosure of Proprietary Interest

HomeTown Health does not have any proprietary interest in any product, instrument, device, service, or material discussed during this learning event.

The education offered by HomeTown Health in this program is compensated by the HRSA FLEX Grant 2017-2018 Rural Hospital Learning Opportunities Program, Iowa Grant # 5888CA04.

Sandy Sage RN

Sandy Sage RN is a Revenue Cycle Analyst who works for HomeTown Health. She works closely with hospitals assisting them in implementing best practice revenue cycle processes. She provides hospital staff education related to all areas of the revenue cycle. She has previously worked as a private consultant for revenue cycle process development and chargemaster compliance in rural hospitals.

Sandy has been an instructor for HomeTown Health University for over 10 years. She is involved in grant programs, functioning as the Iowa SHIP Financial Grant Program Lead. She developed the *Rev Up Your Revenue Cycle* program for hospital benchmarking performance. She has a clinical background in nursing and has worked primarily in rural hospitals throughout her career. In 2000 Sandy transitioned from clinical nursing to the financial side of the hospital and has worked as a Revenue Cycle Analyst since that time.

Sandy is a native of California and moved to Georgia at age 12. She has two grown daughters and currently resides in Cochran, Georgia.

The Role of Patient Access

Learning Outcomes

- List important Patient Access roles in the Revenue Cycle
- Repeat the best phrase to use for upfront collecting
- Describe how Patient Access can contribute to denials
- Identify reasons that upfront collections are more important than ever

What is the Revenue Cycle?

Begins at the first point of contact

Everything in-between

Ends when the patient balance is ZERO

THE REVENUE CYCLE EFFECT

Patient Access in the Revenue Cycle

What role does Patient Access play in Revenue Cycle management?

- Every thing we do in Patient Access affects the efficiency and compliance of the rest of the Revenue Cycle!
- We are the face of the patient experience.
- We are information gatherers
- We are phone operators
- We are money collectors
- We are emotional support
- We are patient transportation
- We are the financial foundation of the entire Revenue Cycle!

Patient Access Role

The **FACE** of the patient experience

Which face are you?????

Data Collection

50-90% of claim denials can be prevented in Patient Access!

GARBAGE IN

GARBAGE OUT

Data Collection

- The biggest complaint in other areas of the revenue cycle is related to errors made during registration!
- HIM, Case Management, Nursing, Coding, IT, Billing, Collections
- Use those complaints to improve your processes in Patient Access
- What affect does incorrect data collection have on the revenue cycle?
  - Denials
  - Re-billing
  - Credit Balances
  - Refunds
  - Patient Safety and satisfaction

- Accuracy in registration is the foundation of the revenue cycle.
- Inaccuracy creates a domino effect
- Case Management/UR first domino
  - No authorization = No payment
- Business Office
  - Wrong information = delay or denial

Order Requirements

- Complete order from the physician
  - Patient Name/DOB
  - Type of test
  - Diagnosis
  - Signature

Eligibility

NOTHING is more important than getting the patient insurance correctly entered into the system!!!!

Always, Always double and triple check your eligibility results.

Scan your results and at the end of your shift, go back and check again!

Codes You Assign

What is an occurrence code?

A code that indicates an event that may affect payment

Codes	Values
01 - 09	Accident Codes
10 - 19	Medical Condition
20 - 39	Insurance Related
40 - 69	Service related
A1 – A3	Miscellaneous

Hiding in plain sight

- 80% of information on a patient's claim or bill originated from the information entered by Patient Access at the time of registration!
- Occurrence codes are assigned by Patient Access when questions are answered on the registration screens

EXAMPLE

- A patient comes in complaining of a swollen ankle. **The PA staff ask the patient** if they remember injuring their ankle. The patient states yes they twisted it the day before but it is more swollen today and it might be broken. Their doctor has sent them over for an x-ray. **The PA staff ask the patient** if they were at work, home or another location when they twisted their ankle. The patient states they were at home working in the flower bed.
- **When these questions are answered in your system an occurrence code 05 with a date is put on the claim**

EXAMPLE continued

What happens if you don't ask the right questions?

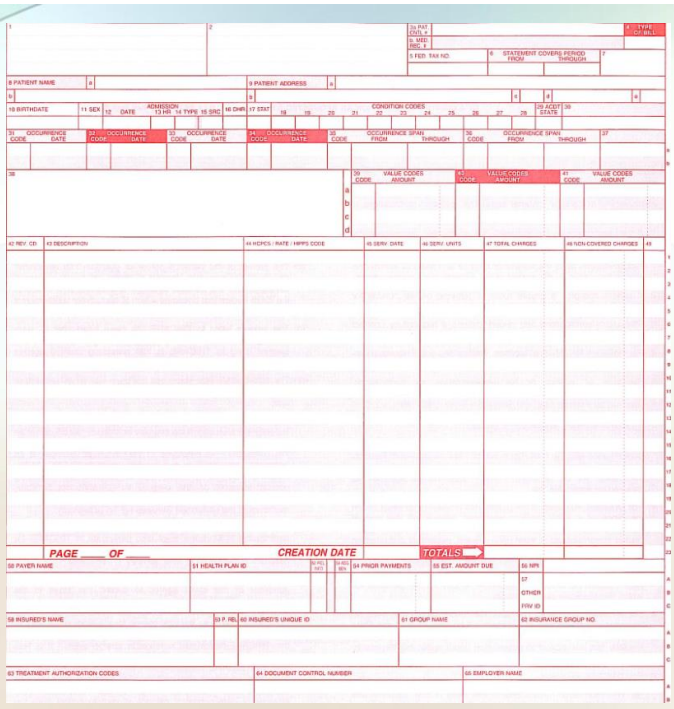
- Correct codes do not cross to the claim.
- Codes do not match the diagnosis
- Claims are rejected
- Payment is delayed
- Productivity decreases

More Codes from PA

- 01 – Auto accident with date
- 02- No fault auto accident with date (no fault states)
- 03 – Accident where a third party is liable with date
- 04 – Accident that is employment related with date
- 05 – Other accident with date
- 06 – Crime victim with date

More Codes from PA

- 11 – Onset of symptoms – The date the patient first became aware of symptoms
- 12 – Date a patient became chronically dependent
- 18 – Date of retirement of patient
- 19 – Date of retirement of spouse
- 21 - UR notice received that stay is not medically necessary
- 23 – Date of Hospice cancellation
- 32 – Date an ABN was issued



Everything is Important

- **Bill Types** are different depending on the patient's admission status. If you assign the wrong status (inpatient, outpatient) the claim will be created on an **incorrect bill type.**
- **Admission Types** are also on the claim; Emergent, Urgent, Elective, Newborn, Trauma
- **Discharge Status Codes** are very important and affect reimbursement. If a patient is transferred you may have to share payment with the receiving facility.

Everything is Important

- **Patient Relationships matter!** Assigning the wrong relationship can affect reimbursement.
- **Precertification Codes** must be correct for accurate reimbursement
- **Date of Birth and Social Security Numbers** must be correct, one missed or incorrect number can cause a denial.
- **Demographic Information** aids in collection and communication and must be verified and correct.

QUESTIONS?

Upfront Collections

Sandy Sage RN

HISTORY

- Historically healthcare has been the type of service that has been provided first and payment received afterwards.
- That has created an environment where patients do not always feel obligated to pay hospitals in full for services received.

Happening Now

- Increases in co-pays and deductibles under the (un)Affordable Care Act (ACA) have led to more patients that are under-insured or uninsured.
- Increasing hospital bad debt
- Increasing patient personal credit issues
- A need to change the way we collect from patients.

Point of Service collections is NO LONGER optional!!

Why Now?

- Upfront collecting will help stabilize the hospital.
- Vital to the financial success of the hospital.

- More than 60 hospitals have closed in the last 6 years.

Your Hospital is counting on YOU!

What can stop us?

- **Difficulty estimating what the patient owes**
- **Feeling like asking for money is bad customer service**
- **Clerks that are not comfortable asking for money**

Notify in Advance

- Pre-registration and scheduling is the best time to notify patients of their financial responsibility.
- Checking eligibility and determining the co-pays and deductibles for high dollar procedures is key.
- Patients do not like to be surprised at the time of service.

Before you collect

- If the patient is uninsured what do you do first?
- Check to see if they are covered by Medicaid!
- Run the patient through portal to see if they have ever had coverage.
- If so, you will want to see if they still qualify.

No Collecting

Who do we not collect from?

Medicare patients that have a secondary insurance or Medicare patients that are only having lab services.

Do collect from all other patients receiving just lab services the way you would for any other outpatient service.

Collecting Upfront

- More than just collecting, you are helping to educate the patient by explaining their benefits and payment options.
- Think about the patient – Would you want to come in for a service and find out you owed a lot of money upfront?
- Giving patients estimates before they arrive will help you collect more because they will be ready.

Confusing Coverage

Insurance benefits are confusing and we may have to explain them to the patient.

- **Annual deductible** – the amount a patient has to pay each year before the insurance company starts contributing to cost of care.
- **Co-Pay** – The amount a patient is responsible for their services. Different amounts depending on the service, i.e. ER, Inpatient
- **Co-insurance** – Percent of the medical expenses the patient is responsible after the deductible is met
- **Out-of-pocket Maximum** – Most a patient will have to pay in a year once met the insurance pays 100%

What are the patient's options?

1. Payment in full at time of service. Accept cash, credit cards, check, debit etc.
2. If they can't pay in full, negotiate what you will accept. For example, if they owe $1000.00 get them to pay $500.00 and set up payments for the balance.
3. Explain how they can pay online.

If they say they can't pay anything, tell them that payment is due at time of service and give them options 1 and 2 again.

4 Things that will help..

- Educating your patient on what their benefits include. If you speak with confidence your patient will have confidence in you as you develop a rapport with them.
- Explaining the options for payment to the patient.
- Including outstanding and old debt in with the expected payment.
- Using the same scripting as your co-workers so the patient doesn't receive mixed messages. How you ask for payment is the key to collecting.

Scripting

- *Mrs. Jones, I have verified your insurance benefits and you have a $250 co-pay for this visit. How would you like to pay for that today? Check, credit card, debit or cash."*

- Don't ask her if she wants to pay today. Just ask ***HOW*** she wants to pay. You know how much she owes and now she does as well, so collect it upfront.

Scripting

- Always tell the patient what they owe and then what the discounted amount would be

- Self Pay:
- *"Mr. Jones the charges for today's visit are $500.00 but after I apply your discount of 40% you only owe $300.00."*

Scripting

- Always include old balances when available
- *"Mr. Jones the charges for today's visit are $300.00 after insurance and you have an old account with a balance of $350 so today's amount due is $650.00. How would you like to pay for that today?"*

Scripting

- If the patient says "I never had to pay upfront before" what would you say?
- *"I'm sorry that you were never asked to pay upfront before but we are requiring payment at the time of service. We can accept payment in the form of cash, check, credit…. I can also check your prior balance and you can take care of that outstanding balance as well. How would you like to pay for that today?"*

Scripting

- If the patient says “I never had to pay upfront before” what else could you say?

- *I’m sorry Mr. Brown but in order for the hospital to continue to provide services, with the rising cost of healthcare, our policies have changed and we do require payment at the time of service. How would you like to pay for that today? Cash, credit etc…”*

Scripting

- If the patient says “I forgot my wallet/checkbook”

- *Mrs. Green, payment is due at the time of service. Would you like to call home? We can take the information over the phone for payment.”*
- *“If no one is home you can call me when you get home with that information or we can reschedule your test.”*

Scripting

- If the patient says “I can’t pay it all today”
- *Well we have already applied your discount and the balance is due at the time of service, could you pay half today and half next month?”*

Scripting

- If the patient says “My ex pays the medical bills, the court says so”
- *You say, “I will be glad to give you a receipt so that he can pay you back”*
- They say, “No he will never pay me back!”
- *You say, “can you call him and let him know payment is due at the time of service? We can take the payment information over the phone”*

Scripting

- *If the patient says " That can't be right, my insurance pays everything"*
- You say, "The great news is we have a contract with your insurance company so you get a discount! I have verified your benefits and this is the amount you will owe after your insurance pays. How would you like to pay today?"

Scripting

- *If the patient says " Just send me the bill"*
- You say, "Just like at the doctor's office payment is due at time of service, how would you like to pay for that today"
- If they get upset or angry
- You can say "I completely understand, we have several options for payment, let me set you up with our financial counselor and she can help you"

Scripting

- *If the patient says, "why wasn't I told before I got here that I would have to pay upfront?"*
- You say, We do our best to try and inform patients of their responsibility prior to arrival. I apologize that you weren't notified. The amount you owe is based on your insurance policy. If you can't pay the full amount we will be glad to set up a payment plan for you. How much are you going to pay today?

Scripting

- *If the patient says, "I don't want to pay for a service before I even have it done"*
- You say, "I understand this is new for you, we have found it works better for patients to know upfront what their responsibility is so you can take care of it now and have no surprises later."

Scripting

- *If the patient says, "I always pay too much and have to wait for a refund"*
- You say, "I know that can be frustrating, we have done our best to make sure our estimate is correct. If you find that you have paid too much, please contact the business office and they will ensure that your balance is refunded promptly"

Tips for Collecting

- Make eye contact with your patient with open body language.
- Always focus on the urgency of the payment, “payment is due at time of service” “the hospital wants to continue to provide services to the community”
- If a patient wants to negotiate start high.
- Establish exact dates for future payments, not just “when I can”

Tips for Collecting

- Be compassionate and empathetic and positive!
- Be firm, be direct, don’t be a pushover
- Don’t respond to anger with anger, always be professional, never raise your voice, stay calm.
- Listen they may need to vent this is a stressful time.
- Don’t let it escalate, bring in a financial counselor or supervisor if needed
- Patients will pay more often than you think if you ask for the money!

Tips for Collecting

Things to Say:

- Here are your options…
- May I suggest….
- Did you know you could…
- We can make arrangements…
- We encourage you to…..
- The great news is…..

Things Not to Say

- I want you to…..
- I need you to…..
- You have to….
- You better……
- Too bad…..

Tips for Collecting

BE QUIET!

There is nothing worse than knowing you owe somebody when they are sitting in front of you making eye contact and waiting.

Emergency Department

- You have the patient's discharge instructions and Rx as they are leaving.
- Stop and tell them you want to double check their information.
- Briefly review their address, phone number and insurance. When they came in they were stressed and unable to concentrate, do the double check.
- Then say "your insurance requires a $50 co-pay, how would you like to pay that cash, check etc.?"

Remember…

- Be financially focused!
- Be assertive not aggressive!
- Support your team!
- Be competitive with a good attitude!

Learning Outcomes

- List important Patient Access roles in the Revenue Cycle
- Repeat the best phrase to use for upfront collecting
- Describe how Patient Access can contribute to denials
- Identify reasons that upfront collections are more important than ever

Questions?

Contact Sandy Sage, RN

Sandy.sage@hometownhealthonline.com

or email

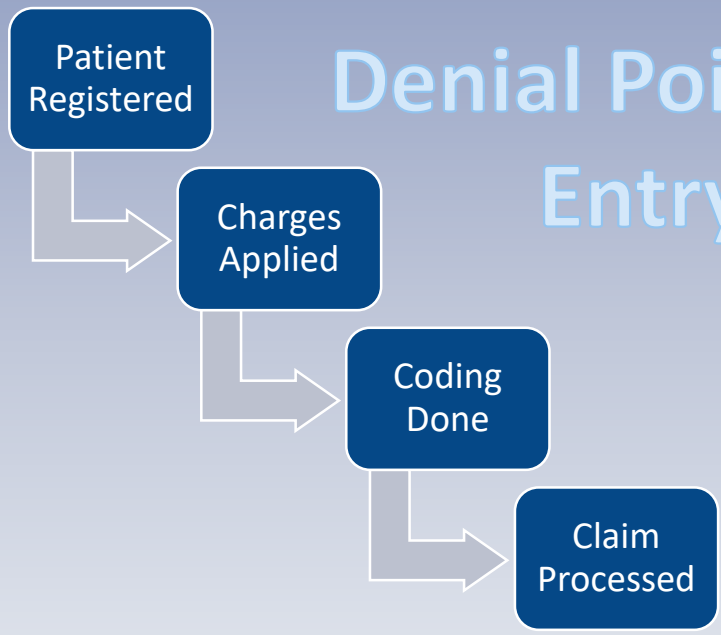
hthtech@hometownhealthonline.com

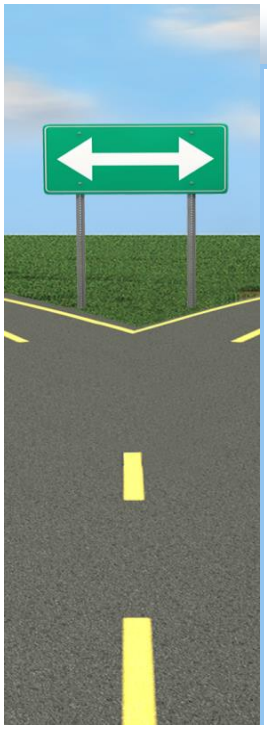
5 Minute Break

Learning Outcomes

- Identify how much it costs per claim to work a denial
- List different types of preventable denials
- Identify different ways to track denials

Denial Points of Entry





Who is Responsible?

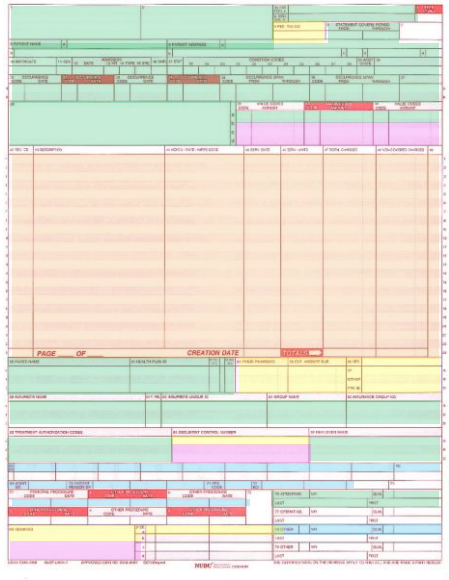
Yellow – System

Green – Patient Access

Orange – HIM/CDM

Blue – HIM Coding

Pink - Billing



How long does it take for a claim to pay?

Clean Claim

15 Days Electronic

30 days Paper

Claims that need work.....

If a claim is not clean the billing staff may have to stop and correct it, sometimes delaying payment.

If a claim is billed with errors it will deny and will need to be corrected and rebilled.

What does it Cost?

Cost to rework a claim due to denial = $25

Denial rates average 10-40% of claims

Almost 60% of claims rebilled after a denial DENY AGAIN!

1000 claims x 20% = 200 claims

200 claims X $25 = $5000

When denials happen…

Timeline

- Registration Edits
- Billing Edits
- RTP Return To Provider
- Remit Denials

Managing the Workload

Claims that deny on your remits take the longest time for turnaround to payment.

Use your system edits to hold claims in your system to avoid sending them to the payer for denial.

This means you need to be analyzing and tracking your denials

Tracking Denials - Traditional

- Track by payer – this allows billing staff to monitor the payers they are billing to keep tracking consistent.
- Pull system reports from your electronic remits along with the Claim Adjustment Reason Codes (CARC)
- Focus each month on your high dollar, high volume denials
- Involve staff from other departments to assist in appeals and implementing edits

Tracking Denials – Out of the Box

- Track by Responsible Department
- See where the denials are originating and hold managers accountable for denial rates
- Provide education for front line department staff
- Let staff know the cost of their errors to the hospital
- Focus on the processes and get staff input

DENIAL FOLLOW-UP/ACTION PLAN

Complete and return to PFS Director within 7 days of _____

Complete form for denials > $1500.00

Account Number _____ **Patient Name** _____

Insurance Company/Payer _____

Claim Number _____ **Amount of Denial** _____

Denial Reason _____

Department/Person responsible for denial:

- ☐ **Patient Access** _____
- ☐ **Case Management** _____
- ☐ **Coding** _____
- ☐ **Ancillary Dept.** _____
- ☐ **Billing** _____
- ☐ **Other** _____

Explanation of error/process causing denial: _____

Tracking Denials - Type

- **Track by classification**
- **Soft Denial** – Temporary denial that you can correct for payment with follow up actions.
- **Hard Denial** – Denials that result in lost or written off revenue. Track using write off codes.
- **Preventable denials** – a ***hard denial*** resulting from action or inaction on the part of the provider. These are elective services that could have been delayed or deferred.

Total Denials vs. Line Item Denials

- How closely are you watching your remits?
- Do you have a system in place to monitor line item denials on outpatient claims?
- How do you track what is being written off?
- Is everything written off to the same adjustment code?
- When can a biller do the write off without authorization?

Avoidable or Faux Denials

- Lack of coverage – could be avoided with accurate eligibility checking
- Coordination of Benefit denials – Could be avoided with eligibility checking and correct attachments and codes added.
- Underpayment denials – Not true denials but can affect reimbursement. Pay attention to your remits to ensure accurate payments.
- Rejected claims – RTP claims that need minor corrections should not be classified as true denials and can have a short turnaround time when staff are working payer edits timely.l

Zero Tolerance for Preventable Denials

- A preventable denial should not happen.
- If preventable denials are happening you need to determine why and correct the causes to prevent further denials.
- They result from action or inaction in your hospital that causes a claim to deny, reject and not pay.
- Use Performance Improvement strategies to correct processes.

Prevention Strategies

- Policies and Procedures implemented with education protect the employee and the hospital. No excuses!
- Preventable denials should reflect on annual evaluations for accountability of the responsible party.
- Creating edits to catch these preventable errors can help with claim payment delays and improve your cash flow.

Clinical Denials

- Denials based on lack of medical necessity, level of care, length of stay.
- You may know about these denials prior to billing the claim.
- They could be total denials based on medical necessity or partial denials from denied days of stay.
- They can be delayed payment claims if more clinical documentation is requested and an authorization is withheld until documentation is received.
- The appeals on these denials should be managed by clinical staff.

Clinical Denials and the CMO

- Chief Medical Officer (CMO) should be a clinical documentation champion.
- CMO should be in contact with physicians with high denial rates.
- CMO should provide education as needed.
- CMO should participate in clinical appeals as needed.
- CMO should encourage peer to peer communication with payers.

Denial Causes and Corrections

Incorrect Insurance Billed

- Set up edits to require ID numbers to match the payer requirements (Medicaid 10 digits, BCBS 9 digits etc.)
- Make Group name and number a required field
- Require copies of insurance cards to enter new payer into the system
- Require proof of eligibility to be in the chart/system (scan, copy etc)
- Keep insurance master files up to date
- Provide eligibility checking tools

Denial Causes and Corrections

Outpatient Medical Necessity Medicare Denials

- These may be written off prior to billing. Use a special adjustment codes to track them.
- They count as preventable denials even if they aren't billed to the payer because the testing was done and no payment received.
- You must have a policy in place for checking medical necessity and issuing ABNs.
- Assign accountability and responsibility.

Denial Causes and Corrections

Prior Authorization required - Outpatient

- Determine who is responsible for obtaining authorization (office, pre-service, scheduling etc)
- Provide contract information to registration staff for authorization requirements
- Educate staff related to location and notes needed for authorizations
- Create cheat sheets for Patient Access to know about authorizations upfront
- Create as many edits as possible to stop claims without authorizations

Denial Causes and Corrections

Prior Authorization required - Inpatient

- Determine who is responsible for obtaining authorization (office, UR, Case Management etc.)
- Implement process for Patient Access to notify whoever is responsible for obtaining authorizations if there is a change in insurance in the account.
- Educate and involve physicians in peer to peer reviews for denied days and stays.

Denial Causes and Corrections

Invalid Modifiers

- Responsibility should be for HIM to apply modifiers to CPT codes.
- Do not allow billing to add modifiers without HIM approval.
- A policy should be written and in place for applying modifiers to claims.
- Education on modifier 59 should be given to HIM and billing staff.

Denial Causes and Corrections

Missing or Timely Record Submissions

- Discuss communication between billing and HIM
- Create a checklist for the person submitting records to payers.
- Use the checklist to ensure all pertinent information is submitted.
- Have a double check system in place to make sure all orders are signed and included.
- Track requests to ensure timeliness
- Complete submissions within 14 days.

Denial Causes and Corrections

Worker's Comp Denials

- Bill according to state regulations
- Always verify WC eligibility relating to the current account. All of the patient's care may not be covered under the WC insurance.
- If you are unable to verify the WC coverage, bill the claim to the patient or their medical insurance.

Denial Causes and Corrections

Missing or Incorrect Demographics and Patient Info

- These denials originate in the registration department or pre-reg.
- **ASK DON'T TELL !!**
- Make all fields required
- Copy and put in record IDs, Insurance cards etc.
- Implement a process to do chart checks at the end of every shift.
- Hold staff accountable for written policies.

Best Practice Idea

Henry County Medical Center

The Business Office approved overtime to work accounts in AR.

Everyone was required to work 4 hours overtime per pay period.

They could only work denials and aged accounts during those hours.

Staff could choose their hours to do the overtime.

AR dropped 8 days after 10 weeks!

Did You Know?

- Only 1 in 3 providers appeal their denials
- Insurance companies use denials to slow payments or avoid paying altogether
- If you don't identify and appeal or correct claims that money is lost forever.
- You have to work to get what is owed to you!

Learning Outcomes

- Identify how much it costs per claim to work a denial
- List different types of preventable denials
- Identify different ways to track denials

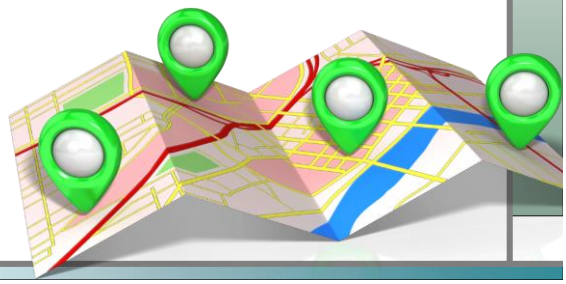
Questions?

Iowa Rural Hospital Learning Opportunity Program

Announcements & Upcoming Events

Dashboard & Resources

A recording of today's webinar, handouts & resources, and future webinars dates can be found on the Program Dashboard located at:
www.hthu.net/iowarhlop18



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IDPH Iowa Department of Public Health

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HOMETOWN HEALTH