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FINANCIAL MANAGEMENT SERIES

Improving Cash Flow Through Revenue Cycle Processes

The revenue cycle encompasses some of the most important business processes in health centers, and is often the most difficult to oversee, control and monitor. Maintaining a revenue cycle with sound and efficient processes can significantly improve cash flow.

This Information Bulletin presents a range of processes that are part of a broadly defined revenue cycle of turning Health Center service delivery into cash.

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REVENUE CYCLE DEFINED – A WHOLISTIC VIEW

The revenue cycle is made up of many processes other than billing and collecting. While the billing department is often the focus of many health centers, the ultimate capability to effectively bill and collect on claims is often determined by many functions that occur long before the claim reaches the billing department. Factors that affect the health center's ability to turn services into cash include functions handled by the appointment desk, registration, information technology, personnel and providers, as well as billing and collections. Rather than the narrow view of billing determining cash flow, the revenue cycle should generally be viewed to include the following functions:

- **Charge structure establishment,**
- **Appointment taking,**
- **Patient registration,**
- **Patient check out,**
- **Coding,**
- **Charge capture,**
- **Billing,**
- **Denial follow up,**
- **Accounts receivable management,**
- **Collecting, and**
- **Cash receipt processing.**

An effective revenue cycle requires that all of these functions be integrated and operate effectively in order for a claim to be paid properly and timely. The effectiveness of the revenue cycle will only be as good as the weakest of the individual processes listed above. The "weakest link" can hinder the entire process and either slow or impair cash flow. The first step in revenue cycle improvement is;

- **Adopt a wholistic view of the revenue cycle and recognize the importance of each individual function to the whole.**

The Groundwork – A Proper Fee Schedule (Chargemaster)

A fee schedule (chargemaster) is an electronic list of CPT codes in the patient accounting system with a price associated with each code. At charge entry, when a particular CPT code is entered, the charge is assigned based on the price associated with that code in the fee schedule (chargemaster.) Therefore, proper recording of charges and revenue is highly reliant upon the health center maintaining a complete, accurate and up-to-date fee schedule (chargemaster.) One mistake that is easily and frequently made is not assigning a charge to certain codes, which results in billing zero related to those codes.

- **Review your health center's fee schedule (chargemaster) for propriety and completeness at least annually.**

Appointment Taking – The Beginning

The appointment taking process can be a critical point at which to accomplish a number of objectives that later result in cleaner claims and better collection rates.

- **Obtain patient demographic information at the time of the appointment.**
  Having this information saves time during registration and usually results in more accurate information being obtained.

- **Inquire about insurance or other third-party coverage at the time of the appointment.**
  The appointment clerk can engage in a discussion with the patient related to their financial responsibility, documentation that should be brought to the appointment, and other information designed to help establish proper patient expectations.

- **Train appointment clerks to assess a patient's needs in order to schedule with the appropriate provider.**
  Appointment clerks should have suffient training related to the health center's various programs to assist in assessing qualification for assistance under the programs.

- **Establish the appointment function separate from registration.**
  For most health centers, registration is a very busy place. Gaining the advantages of an effective appointment desk is usually easier if an appointment function is established separate from registration.

Registration – The Primary Determinant of Clean Claims

Of particular importantance is the connection between registration and billing. The reliability of information gathered at registration can have a significant impact on the health center's capability to bill and be paid for claims. As a result, registration and billing must work together as an integrated, seamless team to collect proper informaton for claim submission.

- **Communicate regularly and support each other.**
  If your billing and registration functions do not work together, consider implementing a billing task force made up of individuals working in these areas to open lines of communication and improve cooperation.

- **Hire and retain quality employees for the registration desk, provide regular and ongoing training, and analyze your payscale.**
  Because the information collected at registration is so critical, it is important to hire and retain quality employees for the registration desk and provide regular and ongoing training. High turnover at registration is common in many health centers and results in high training costs and increased error rates, which ultimately result in denied claims. Turnover is often caused by other health care organizations (such as hospitals and physician practices) recruiting health center registration personnel after the health center has made the

investment in training. Analyze your pay scale for registration personnel compared to similar positions available in your market.

- **Provide regular and ongoing training for registration clerks.** High registration error rates are detrimental to cash flow. Simple errors, such as misspelled names, incorrect insurance numbers, etc. often slow claim payments. In addition, classifying a patient in an incorrect payer category will result in denied claims. In some cases, a patient may not be assigned to a payer category at all, and these charges can get lost in the system and never be billed or collected. Registration error rates must be monitored and the results used for training and permanent correction of problems at the source.

- **Implement a verification process.** In recent years, verification systems for insurance coverage for some large payers have been greatly improved, and electronic verification systems are not unusual. For major payers, it is wise to implement a verification process, particularly where an efficient electronic solution is available.

Patient Checkout – Relieve Registration and Billing

Utilizing patient checkout appropriately can improve collections, patient flow, document flow and follow up appointment accuracy. A good checkout process will take a lot of weight off both registration and billing.

- **Deliver every patient to checkout and enter charges.** Entering charges at checkout rather than in billing will avoid backlogs and use of billing resources for data entry.

- **Attempt to collect amounts due from patients.** Checkout personnel should also attempt to collect amounts due from patients and should be trained in collection practices.

Coding – Close the Gap

The majority of health centers code and bill services directly from the encounter form. Therefore, the accuracy of provider coding that matches the information in the provider's notes for the encounter is important. However, many health centers experience differences between the actual documented visit notes and the encounter form such as:

- **Diagnosis, signs and symptoms documented are different;**

- **Procedures performed are not accurately stated on the encounter form;**

- **Reasons for ordering ancillary tests do not meet medical necessity.**

If a health center has a high claims denial rate due to diagnoses that do not meet medical necessity and/or fails to identify procedures that were performed because the provider did not indicate the service on the encounter form, reimbursement may be lost. Consistent, inaccurate coding of patient diagnoses due to the omission of proper diagnosis codes on the encounter form may also result in inappropriate reimbursement. The gap between coding and reimbursement lies in the provider's documentation.

- **Review a sample of providers' visit notes and compare them to encounter forms.** In order to bridge this gap, personnel knowledgeable in coding and billing of encounters should periodically review a sample of provider's visit notes and compare them to encounter forms.

- **Use information from the review to provide communication and training.** Information obtained from this review should then be used to provide communication and training to providers related to coding and billing issues.

Statistics are gathered from healthcare databases and case mix indexes are derived from this data for specific geographical areas. Physicians often utilize this information to choose locations in which to work and live. Insurance companies use this information to identify which

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providers they will choose to contract with. The importance of accurate coding goes well beyond the desks of the personnel responsible for the coding and billing of encounters.

- **Educate health centers' coding and billing staff in proper coding and billing of services based on the provider's notes, the encounter form and other supporting documentation.** The encounter form is a tool to assist in different functions throughout the health center. As such, coding and billing staff should not be dependent on this document alone. When a third-party payer requests documentation to validate a claim for payment (or when a health center is audited by Medicare or Medicaid), the health center is asked to submit a copy of the encounter form and complete supporting documentation for the billed services.

- **Implement a review process within the health center or utilize outside assistance.** The review process is a step toward compliance and is an indicator to oversight agencies such as the Office of Inspector General (OIG) that a health center is attempting to bill appropriately.

The goal for all health centers is to obtain payment as quickly as possible. Designing a process to review and monitor coding and billing compared to the provider's notes should improve the quality and accuracy of coding, allowing the billing process to occur more efficiently. And clean claims mean better cash flow.

Charges – Get Them ALL

Health Centers can not bill for services that are not documented or where documentation is lost.

- **Train providers to fully complete fee tickets (encounter forms) and record appropriate levels of services.** Without training, providers often tend to undercode, resulting in lost revenue to the health center. Fee tickets (encounter forms) must be carefully accounted for and charges posted in a timely manner. Lost fee tickets (encounter forms) are a frequent problem resulting in missed revenue opportunities.

- **Number fee tickets (encounter forms) in a numerical sequence and account for them on at least a weekly (if not daily) basis.** All fee tickets (encounter forms) should be posted within 24 hours of services being provided in order to permit timely billing and speed up cash flow.

Billing – Submit All Payers

Health center billing departments frequently inadvertently fail to bill certain accounts. Sometimes these problems are a result of sytem problems and claims become "stuck." These problems have become more pervasive as electronic billing has grown. Other times, billing is not accomplished due to uncertainty or lack of knowledge among billing staff resulting in large numbers of claims not being billed. One thing is certain – you won't get paid if you never send a bill.

- **Establish proper monitoring of the billing function to ensure that all bills are sent.** Don't leave money on the table.

Denials – Easy Money

Often unknown to health center management, a large number of denials result in claims not being paid. Denial follow-up is time consuming, so monitoring and reducing denials is the best policy.

- **Make it a priority to follow-up denials** Denial of claims often only need a simple correction in order to be paid – easy money. Improper handling of denials can significantly reduce cash flow. Therefore, all denials should be rebilled within 10 days.

- **Determine the reason for the denial and fix the problem.** Fixing the problem at its source is the way to avoid similar denials in the future.

Accounts Receivable – Monitor, Monitor, Monitor

Most serious revenue cycle problems can be identified through diligent monitoring of accounts receivable.

- **Produce and review an aging of accounts receivable report by payer type on at least a monthly basis.**

This report shows amounts due the Health Center in aging buckets, such as current, over 30 days, over 60 days, etc., by payer type, such as Medicare, Medicaid, self-pay, etc. Lack of regular review of accounts receivable will allow problems to go unidentified and dollar amounts associated with problems to grow over time.

- **Monitor certain benchmarks related to accounts receivable.** Days in accounts receivable is the most popular monitoring benchmark for accounts receivable. This usefulness of days in accounts receivable can be improved by computing days in accounts receivable by payer type on a regular basis.

Collection – Money For The Mission

Health centers should attempt to collect amounts due from patients and have effective collection policies and account follow up.

- **Make every attempt to collect amounts due from patients at the time of service.**
- **Where this is not possible, have collection and follow up policies in place to improve chances of collecting later.**

These include:

- **Referral of past-due accounts to a collection representative at check-in,**
- **Sending of patient statements monthly,**
- **Having sufficient collection staff, and**
- **Using collection letters and phone calls.**

Health centers that place emphasis on patient collections and follow through on established collection policies are frequently successful in maintaining adequate cash flow.

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Cash Receipt Processing – A Place for Strict Procedures

Cash receipts should be posted and deposited intact the same day they are received. No checks should be held. In addition, maintaining proper internal controls over incoming payments is critical.

TECHNOLOGY – USE IT TO YOUR ADVANTAGE

Many technological solutions currently exist to improve the efficiency and flow of revenue cycle information and documents. Many health centers have not yet taken advantage of some of the following effiency-improvement technology:

- **Electronic encounter forms,**
- **Automated verification of coverage,**
- **Electronic billing,**
- **Electronic payment and posting, and**
- **Automated contract monitoring.**

The less paper you shuffle, the more claims can be processed and billed in a timely manner.

IMPROVEMENT – KNOW WHAT'S HAPPENING

Having efficient and effective processes throughout the revenue cycle functions of a health center is critical.

- **Have daily procedures to ensure smooth flow of information, documents and people.**

  Lack of sufficient processes can result in backlogs, inadequate patient care, long wait time and sluggish cash flow.

- **Include the following process improvement activities.**

1. Interviews of personnel regarding day-to-day processes and procedures. This step should include reviewing all of the revenue cycle processes from beginning to end – step by step to gain a detailed and thorough understanding of each process.

2. Examination of documentation regularly used as part of each process. This includes examining the supporting documentation related to each process, including forms used, balancing procedures, etc.

3. Identification of problem areas or opportunities for improvement. As areas are reviewed, problems, backlogs and other issues should be identified. Solutions to problems areas should then be considered and improvements sought.

4. Implementation of best practices in the industry. Implementation should be based upon a detailed action plan with time requirements. Improvements implemented should be based upon best practices in the industry whenever possible.

A detailed review of daily processes often turns up problems and deficiencies unknown to management and allows them to address such problems. In addition, improving processes can result in fewer problems and errors and better productivity. Increasing efficiency often means fewer employees are needed to do the same work. Process improvement in the revenue cycle is a significant focus for many health centers, because **improving processes impacts the bottom line.**

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