CHAPTER 6
REVENUE CYCLE MANAGEMENT

LEARNING OBJECTIVES

In this PowerPoint presentation, we will learn about:

- ❖ **Revenue Cycle Management in Healthcare**
- ❖ **Stages in Revenue Cycle Management**
- ❖ **Healthcare Revenue Cycle Process**
- ❖ **Revenue Cycle Management – Problems & Solutions**
- ❖ **Revenue Cycle Management System**

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE

Revenue is defined as "income, especially when of an organization and of a substantial nature" by Oxford Dictionary.

Revenue is the money a company receives in payment for its products or services.

Revenue is not the profit, but instead, it is the total amount of money earned by an organization before deducting any expenses or taxes.

Revenue has a significant impact on the profit. It is important to create the widest possible difference between the cost and the revenue of the business.

Profit = Revenue – Cost

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE IN HEALTHCARE

"*All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.*" Healthcare Financial Management Association (HFMA)

Healthcare revenue cycle involves several steps such as patient registration, insurance verification & eligibility, medical documentation, chart review & coding, claim submission, payment posting, and accounts receivable & collections.

Any incorrect or erroneous entry at any point in the revenue cycle can turn it into a vicious cycle. The farther an erroneous entry moves into the revenue cycle the more difficult it becomes to trace and rectify it.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT IN HEALTHCARE

Revenue Cycle Management (RCM) in healthcare is the process of managing claims process, payment, and revenue generation.

RCM in healthcare helps a medical practice to increase the revenue by proper claim management.

If the claims are paid partly or if it is paid after a long period of time, then resources from the accounts receivable and collection department need to be utilized in order to get the claim settled.

This delay in claim payment and consecutive follow-ups from the accounts receivable and collection department would generally have a negative effect on the revenue cycle.

DO NOT COPY

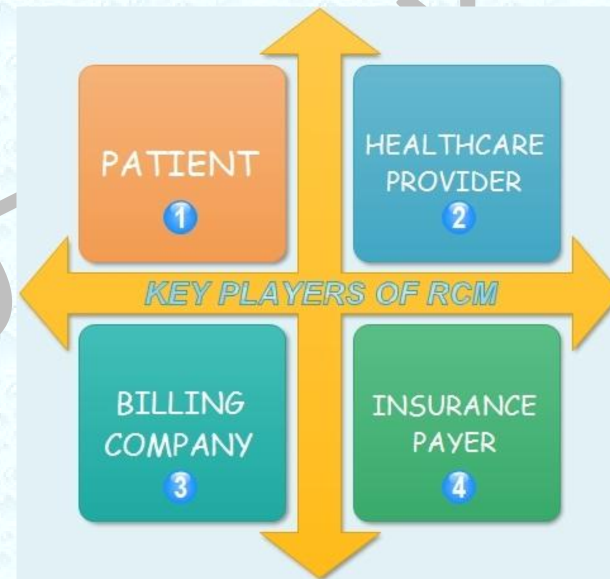
CHAPTER 6
REVENUE CYCLE MANAGEMENT

KEY PLAYERS IN REVENUE CYCLE MANAGEMENT OF HEALTHCARE

Time management and productivity play key elements in the healthcare RCM.

There are four key players involved in the Revenue Cycle Management of healthcare system namely:

- ✓ **Patient**
- ✓ **Healthcare provider**
- ✓ **Billing company**
- ✓ **Insurance payer**



It is imperative that all the four players align their goals and work in tandem so that the revenue cycle process runs smoothly.

DO NOT

REVENUE CYCLE MANAGEMENT

STAGES IN REVENUE CYCLE MANAGEMENT

Due to the automation of the revenue cycle process, today, computers have replaced the typewriters used by the medical transcriptionists, servers have replaced the file cabinets used to store the medical records documentation, electronic dictionaries and softwares have replaced the traditional dictionaries and coding manuals, and electronic data interchange (EDI) has replaced the US Postal Service to send claims.

This automation has led to reduction in the billing cycle period as well as decrease in the amount of errors.

Having said that, human interference still is very crucial in the RCM process to help it run in an effective manner.

DO NOT COPY

weschool S.P MANDALI'S Welingkar Education

CHAPTER 6
REVENUE CYCLE MANAGEMENT

STAGES IN REVENUE CYCLE MANAGEMENT

Efficient practice management software (PMS) seamlessly integrates patient registration, insurance verification & real-time eligibility, medical documentation, chart review & coding, claim submission, payment posting, and accounts receivable & collections.

If a single software handles the whole RCM process, it would be easier to detect mistakes early on and rectify it in a timely manner, thereby preventing any ripple effects that would occur later on during the process.

A medical practice's choice of practice management software (PMS) should be largely centered on how the RCM needs to be implemented.

DO NOT COPY

STAGES IN REVENUE CYCLE MANAGEMENT

A right choice of PMS would lead the medical practice on the path of ascent; whereas a wrong choice of PMS would lead the medical practice on the path of descent.

Researchers from the California Nurses Association analyzed data reported by the insurance payers and found out that 22 percent of all the claims submitted were rejected.

It is believed that out of all the claims rejected (22%), almost 40% are never re-submitted due to claims being lost/missed, the claim resubmission is done after the time deadline specified, or the healthcare provider purposely does not resubmit the claim thinking that the amount is not significant enough to go through the hassles of appeals and follow-ups.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

STAGES IN REVENUE CYCLE MANAGEMENT

One other important reason to develop an efficient revenue cycle is working on claim denials and claim rejections.

Maximum number of these claims is denied for trivial reasons and RCM helps to identify those insignificant cause and root it out so that lesser amount of denial occur thereby increasing the medical practice revenue.

DO NOT COPY

A proper revenue cycle management works on each and every stage of the revenue cycle to increase the payments and collections while decreasing the write-offs.

CHAPTER 6
REVENUE CYCLE MANAGEMENT

STAGES IN REVENUE CYCLE MANAGEMENT

In a nutshell, we can describe the revenue cycle as consisting of three stages:

1) Preservice Stage.
2) Service Stage.
3) Postservice Stage.

Preservice Stage:

Preservice stage consists of all the activities prior to the patient's encounter with the healthcare provider or in other words prior to the patient receiving any kind of healthcare service.

The patient's call to the medical practice, gathering of the information – patient's demographic and patient's insurance, verification of the insurance information, real-time eligibility, authorization information, and financial position of the patient – payments due in the past all these form part of the preservice stage.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

STAGES IN REVENUE CYCLE MANAGEMENT

Service Stage:

Service stage is the actual point where the patient receives the healthcare service for the medical ailment. This stage is the core activity stage of the revenue cycle management.

The patient visiting the clinic/hospital, patient's encounter with the healthcare provider (provider's examination, diagnosis, and treatment plan), medical transcription, medical coding, and medical billing are part of the service stage.

The service stage consumes most of the resources of any medical practice.

DO NOT COPY

STAGES IN REVENUE CYCLE MANAGEMENT

Postservice Stage:

Postservice stage is the last stage of the RCM after the healthcare service to the patient has been delivered.

Claim submission, patient statement/invoice, payment posing, accounts receivable, working on denials and appeals, write-offs and refunds, and assigning to collection agency form part of the postservice stage.

To summarize, the three stages of RCM is comprised of all the administrative, clinical, and financial functions of a medical practice.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

Generally, a revenue cycle process involves the following ten steps:

1) Patient Verification & Scheduling
2) Patient and Provider Encounter
3) Medical Transcription
4) Charge Entry
5) Medical Coding
6) Claim Submission
7) Payment Posting
8) Accounts Receivable
9) Write off, Refund, & Collections
10) Closing of Account

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

HEALTHCARE REVENUE CYCLE PROCESS

1) Patient Verification & Scheduling:

This is the first step in the process which kick starts the revenue cycle.

It includes the preregistration, verification, and scheduling process.

Preregistration is usually done through phone call or online patient preregistration portal (Apollo Hospital).

After the details are obtained by the office medical staff either by online portal or by phone call, insurance eligibility is confirmed with the health insurance payer via batch or real-time eligibility. If all the above processes are successful, the patient's appointment is scheduled.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

HEALTHCARE REVENUE CYCLE PROCESS

1) Patient Verification & Scheduling:

Also at this stage, the medical office staff will counsel the patient regarding their financial obligation called the patient's responsibility.

This process includes the following activities:

- ✓ Inform the patient about the copay, coinsurance, and deductible.
- ✓ Obtain a signed consent form for treatment and PHI privacy.
- ✓ Obtain an Advance Beneficiary Notice of Noncoverage (ABN) form, if required.
- ✓ Obtain an Advance Directive form. This is usually obtained for inpatient services.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

Advance Beneficiary Notice of Noncoverage & Advance Directives

Advance Beneficiary Notice of Noncoverage (ABN) is an undertaking signed by the patient to pay from his own pocket for the medical service delivered by the provider.

Advance directives may be a form, living will, or power-of-attorney documents written in advance mentioning the patient's choices for medical services or mentioning the name of a person who can make those choices for the patient in case the patient is unable to make decisions.

Example: If the patient lapses into coma or is suffering from Alzheimer, etc.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

HEALTHCARE REVENUE CYCLE PROCESS

In non-emergent condition, registration, verification, and counseling are performed before admitting the patient but in emergent condition hospital has to follow EMTALA directives.

Because of the Emergency Medical Treatment and Labor Act (EMTALA) rule passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA), United States hospitals are obligated to treat patients coming to the emergency department.

The triage nurse (nurse who attends accident and emergency cases in the hospital) will assess the patient and treatment will begin in order to stabilize the condition of the patient without waiting for the patient registration and insurance verification.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

2) Patient and Provider Encounter:

The patient's initial encounter with the healthcare provider occurs at this point.

The provider will interview the patient and perform a physical examination. The more structured and detailed the interview of the patient, the easier it will get for the provider to develop a working diagnosis for the patient.

Based on the observation, the provider will chart out the recommendation and plan for the patient and will record it for the medical transcription department to create the medical report.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

3) Medical Transcription:

Some tech savvy healthcare providers tend to document the medical report on their own with the help of various different types of functions built within the EMR/EHR applications in the form of voice recognition, template creation, macro creation, etc.

But significant amount of healthcare providers still follow the traditional approach of dictating and recording the audio file, which is then accessed by the medical transcriptionist (in-house or outsourced) and a medical report is created for the respective patient.

This medical report will contain all the billable medical services provided to the patient for the medical coding team.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

4) Charge Entry:

In this process, charges are entered, that is, all the details are keyed in at this juncture.

This is the point in the revenue cycle where the claim or bill is actually generated.

A medical biller is assigned with the job of charge entry, where in, a unique account for the patient is created for reference. It is this unique account number that will be used to query for any issues regarding claim or for use in the future to access the patient's account details from the medical billing software.

The medical biller will also enter the demographics of the patient, the insurance details, and charges of the medical services into the medical billing software.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

5) Medical Coding:

It is the key step in the revenue cycle process.

It is one of the most skilled administrative departments of the hospital requiring good medical, interpersonal, comprehensive, and analytical skill.

They comprehend the medical report, interact with the providers, and assign medical codes to each of the billable service.

Each and every service for which the healthcare provider needs to be reimbursed should be assigned a unique diagnosis or procedure code.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

5) **Medical Coding**:

The diagnosis code is assigned with the help of ICD-9 coding manual (ICD-10 is set to be implemented from October 1, 2015), while the procedure ancillary services code is assigned with reference from the CPT or HCPCS.

The diagnosis code and procedure code should match up in order to be reimbursed.

If there is a mismatch between the diagnosis code and procedure code or the diagnosis code is not definitive enough (not coded to the highest specificity), the claim will be denied.

Claim scrubbing is rapidly being integrated as a basic feature in all the leading medical billing software. Claim scrubbing is the process of verifying the claims for any errors and checking its format compatibility with the insurance payer.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

6) Claim Submission:

Claim submission beckons the start of the postservice stage.

Choice of correct claim form (CMS-1500 for professional and UB-04 for institutional) and with the right charges entered into the specific data fields of the claim forms are important to convey the information to the insurance payer.

Some hospitals submit the claims directly while others appoint a clearinghouse to submit the electronic claims.

Before the submission of the claim to the insurance payer, it should be thoroughly inspected for accuracy, integrity, and compliance set by the statutory bodies.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

HEALTHCARE REVENUE CYCLE PROCESS

6) Claim Submission:

Clearinghouses are intermediaries between the healthcare practices and insurance payer that help to transmit electronic claims to the insurance payers in a secure way.

Claim adjudication is the process of paying the submitted claims or rejecting or denying them after examining the claims to the benefit or coverage requirements.

The insurance payer will send an EOB or ERA explaining the outcomes of claim adjudication process.

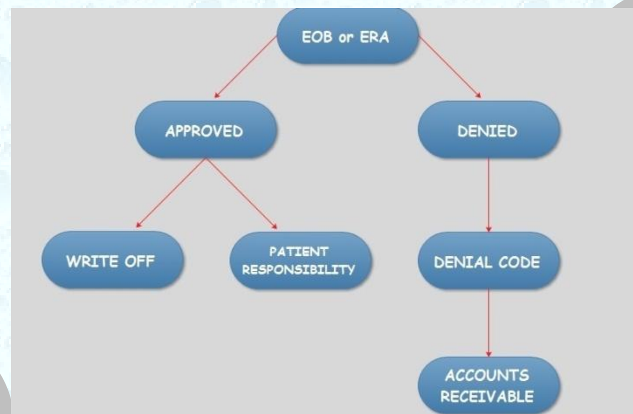
Typically, the three outcomes of a claim adjudication process are accept, deny, or reject.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

7) **Payment Posting:**

It is the job of the medical biller to do the payment posting, i.e., entering the details of the EOB/ERA into the respective patient's account.



The medical biller has to enter the denial code for the accounts receivable to follow up and prepare the patient's invoice.

DRAFT COPY

HEALTHCARE REVENUE CYCLE PROCESS

8) Accounts Receivable (A/R):

According to the Practice Profitability Index (PPI), 65% of physicians see declining reimbursement rates as the top issue negatively affecting medical practice profitability. CareCloud and QuantiaMD.

The declining reimbursement rates coupled with the rejection rate of claims by the insurance payer will act as an impediment to the growth of any medical practice.

This timely and proactive measure to palliate the adverse effects of rejection rate of claims is overseen by the accounts receivable department as they play a decisive role in keeping the accounts receivable within the 120-day-limit.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

HEALTHCARE REVENUE CYCLE PROCESS

Difference Between Claim Rejection & Claim Denial

There are always instances where a claim is denied or rejected.

	Claim Rejection	Claim Denial
Time	These claims are rejected before going into the adjudication process.	These claims are denied after going into the adjudication process.
Record	No record for the claim rejection is kept with the insurance payer.	Record for claim denial is kept with the insurance payer.
Response	An electronic claim error is sent to the billing company.	An EOB/ERA is sent to the billing company.
Action	Rejected claims need to be re-submitted as a new claim after making necessary changes.	Denied claims are appealed after appropriate correction.
Examples	Claim form format error, inaccurate patient's date of birth or policy number, sent to wrong insurance payer, etc.	Diagnosis and procedure code mismatch, illegible claim, etc.

HEALTHCARE REVENUE CYCLE PROCESS

8) Accounts Receivable (A/R):

A structured and well-organized accounts receivable department is essential to carry out the process of generating different kinds of reports which will help in analyzing the pain points and effective measures to be taken to counteract the causative factor.

The reports can be obtained in the form of spreadsheet or graphical representation.

Some of the important types of reports generated by most of the AR department are as follows:

(a) Collection Aging Report.
(b) Procedure Payment Analysis Report.
(c) Insurance Carrier Report.
(d) Key Performance Indicator Report.
(e) Denial Management Report.

DO NOT COPY

HEALTHCARE REVENUE CYCLE PROCESS

9) Write-Off, Collection Agency, & Refund:

There will always exist a class of patients who are delinquent to make the payments.

Having identified those accounts and ensured that all efforts have been made by the AR department to collect the payment, the AR department is left with two options, either write off the account or send it to a collection agency.

Write-Off amount is the amount that the healthcare provider deducts from the billed amount and does not expect to collect, thereby "writing it off" the accounts receivables owed by payers or patients.

Usually, if the amount is nominal, it may be written-off, but if the amount is significant, it is turned over to the collection agency.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

HEALTHCARE REVENUE CYCLE PROCESS

10) Closing of Account:

This is the last step of the postservice stage as well as the revenue cycle as a whole.

Once the final payment is received and recorded by the medical billing department, the revenue cycle for that respective claim is complete. At this stage, the balance of the account is zero.

All the documentation for that particular claim will be filed accordingly for any future reference and financial report generation.

Every organization has their own specific way of working and need to reinvent their revenue cycle based on their specific needs and resources to successfully enhance their productivity and profitability.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT – PROBLEMS & SOLUTIONS

Revenue Cycle Management (RCM) in healthcare is the process of managing claims process, payment, and revenue generation.

The main objective of any revenue cycle management is to ensure that the claims are paid up to the maximum possible threshold within a specific period of time.

On close dissection of the 10-step revenue cycle process, it can be noticed that over the life of the revenue cycle there are scores of opportunities where simple errors can creep into the cycle.

The core competence of a dynamic revenue cycle management lies in detecting these errors, getting to the root cause of it, and implementing policies that would annihilate or exterminate such errors from occurring in the future.

DO NOT COPY

REVENUE CYCLE MANAGEMENT – PROBLEMS & SOLUTIONS

Errors during preservice stage

Problem: This is the stage where a significant amount of errors occurs in the revenue cycle. Errors range from typing in inaccurate demographics of the patient, keying inaccurate insurance information of the patient, not verifying the patient's eligibility, not obtaining preauthorization, etc.

Solution: The medical practice should always hire trained and well-educated staff to handle the registration and verification process.

A real-time eligibility of the patient's insurance coverage should be performed without fail.

DO NOT COPY

REVENUE CYCLE MANAGEMENT – PROBLEMS & SOLUTIONS

Errors during service stage

Problem: This stage involves errors in the form of inability to collect the copay or coinsurance, inaccurate coding, improper claim form, etc.

Solution: The office staff should be instructed to communicate to the patient about the copay, coinsurance, or deductible not met before the scheduled appointment and after eligibility verification. This would reduce the outstanding on the patient's responsibility.

An internal scrutiny should be performed to ensure there is no mismatch between the diagnosis code and the procedure code, to check for the completeness of the claims, and to check for accuracy of the claims before it is sent to the insurance payer.

DO NOT COPY

REVENUE CYCLE MANAGEMENT – PROBLEMS & SOLUTIONS

Errors during postservice stage

Problem: The errors that occur in the postservice stage are delay in refunding the overpayments, inability to collect the patient's responsibility, inefficient management of rejected or denied claims, etc.

Solution: The accounts receivable department should generate all kinds of reports possible in order to track the claim's life at each and every stage.

Accounts receivable department should hire staffs who are polite so as to patiently listen and answer all the queries raised by the patient, and in case, the patient is unable to pay should guide them towards certain other avenues such as obtaining a financial aid or an interest-free loan, etc.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT SYSTEM

A desirable revenue cycle management solution should have the capability to shorten the billing cycle by assisting the medical billing department in producing more and more clean claims and less and less write-offs.

It is imperative to choose a good revenue cycle management solution as it has the capacity to make or break a medical practice.

Some of the basic features of a revenue cycle management solution are as follows:

- **Real-Time Data**
- **Ability to Integrate and Upgrade**
- **Security**
- **Hybrid (Professional and Institutional)**
- **Patient Focused**
- **Mobility**

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT SYSTEM

Real-Time Data

A revenue cycle management solution should be able to generate real-time data instantly and make them available for use by the front-office staff, back-office staff, and the providers.

There are typically three types of real-time data required in the revenue cycle, viz,

Real-time eligibility (Used by the front-office staff)

Real-time report generation (Used by the back-office staff)

Real-time clinical information (Used by the providers)

These detailed reports are used for effective decision making that would help in proper management all aspects of patient's care such as clinical, financial, and administrative.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT SYSTEM

Ability to Integrate and Upgrade

In this dynamic environment where rules are constantly changing, the medical practice should have a revenue cycle management system that offers great level of flexibility and scalability to adapt to changing business rules at any time in the future.

The integration of the RCM system with other applications used in the hospital will allow for easy data sharing across the healthcare delivery system, because a blend of heterogenous systems will not only make it difficult to identify problem-causing areas but also make it extremely difficult to generate reports.

Therefore, an RCM system should be dynamic with ability to integrate with other application as well as to be upgraded as and when needed.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT SYSTEM

Security

An RCM system should have a robust and comprehensive security feature.

Care should be taken to ensure that the system is HIPAA certified as it would play a critical role in determining the HIPAA compliance process of the medical practice.

It should have enough administrative, physical, and technical safeguards to prevent the misuse of any protected health information.

Features such as role-based access control, unique username and password, data encryption, etc., are essential for any RCM. Role-based access control is restraining an individual to access only those files and folders which are essential to perform the individual's job duties. Level access is granted strictly to only minimum required data depending on the employee's job responsibilities.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT SYSTEM

Hybrid (Professional and Institutional)

An ideal RCM solution should be able to handle both the professional-side and the institutional-side billing.

According to the recent reports, hospitals are on a buying spree or are forming hospital-provider partnership. Hospitals are aggressively taking over private medical practices to increase their patient base hoping to increase their profitability. Therefore in this existing market where marriage between hospitals and practices are growing rapidly, an RCM system which can handle both the professional and institutional billing and integrate seamlessly will be advisable.

One other function would be for the RCM solution to be able to handle different insurance carriers effectively without any standard incompatibility.

DO NOT COPY

CHAPTER 6

REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT SYSTEM

Patient Focused

Lately, patients have become more aware and want to actively participate in the clinical and financial decisions regarding their healthcare. If patients on a regular basis can track their ongoing healthcare progress both in terms of clinical and financial aspects, it would greatly help in making an informed decision and would help in developing a positive relationship between the patient and the provider.

HIPAA encourages utilizing healthcare technologies to increase patient involvement in order to be eligible for the incentive program set up by Medicare and Medicaid.

The patient's involvement into joint decision making will also healthcare providers cut costs on several grounds such as registration and scheduling (by engaging online pre-registration forms), financial counseling (by allowing the patient to calculate an estimate of patient's responsibility), collections (by electronic fund transfer from patient's account), etc.

DO NOT COPY

CHAPTER 6
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE MANAGEMENT SYSTEM

Mobility

Healthcare providers are always pressed for time and require a kind of RCM system that would help them do their job function even on the move.

Having a real-time situation of a particular account or the medical practice anytime and anywhere would enhance the ability of the providers to perform their job duties more efficiently.

Lately, mobile applications such as cell phone, laptops, and tablet PC are playing a major role in revenue cycle management.

DO NOT COPY

IMPLEMENTATION OF REVENUE CYCLE MANAGEMENT SYSTEM

An RCM system sporting the above features would cause a positive impact on the revenue cycle managing the financial aspects as well as clinical aspect of care and at the same time changing towards a better care coordination.

Implementation of a wrong RCM system would impact the hospital's financial stability and affect future performance.

One fundamental question that needs to be kept in mind before zeroing down on an RCM system is to review the need and budget of the medical practice/hospital and select a system that fits within the hospital's budget as well fulfils the current and future needs.

DO NOT COPY