Treasury and Cash Management

BKD
CPAs & Advisors

Presenter

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Agenda

1. Cash Management and Measurement
2. Using Revenue Cycle to Enhance Capital
3. Overall Revenue Cycle Key Performance Indicators
4. Closing and Q&A

Cash Management Definition

- **Cash management comprises the operational and banking processes associated with the collection, aggregation, holding and disbursement of cash.**
  - ✓ Specific accountabilities for the efficient, effective and ethical use of resources.
  - ✓ Requires the business processes associated with the collection, aggregation, holding and disbursement of cash to be integrated within the organisational structure and business operations of an agency
  - ✓ Approach will vary based on size, geographical distribution, and the nature of its operations
  - ✓ Assists an organization to make informed strategic decisions in relation to projected cash requirements, forward planning and asset replacement
  - ✓ Contributes towards the generation of income from investing activities and the reduction of debt-servicing costs

Key Elements of Cash Management

The elements of effective cash management include:	Accurate and timely cash flow analysis and forecasting
	Maximising returns from cash balances
	Minimising financing and borrowing costs
	Efficient banking arrangements
	Efficient accounts processing arrangements
	Efficient debtor management and collection of receivables
	Effective control of payments and disbursements

Cash Management Key Indicators

- Important to measure and benchmark cash management performance (benchmark against historical performance if necessary these are stand-alone hospital benchmarks)

2020 Median Financial Ratios by S&P Rating[1]	A[2]	BBB[2]
Salaries and Benefits / Net Patient Service Revenue %	69.1	61.9
Maximum annual debt service coverage	4.8	4.0
Operating lease-adjusted coverage	4.0	3.6
Debt Burden %	2.7	3.7
Non-operating revenue/total revenue (%)	3.4	1.8
EBIDA Margin (%)	10.0	9.0
Operating EBIDA Margin (%)	8.7	8.3
Operating Margin (%)	-0.1	3.3
Excess Margin (%)	4.7	3.7
Capital Expéditeurs/Der. & amort. Expo. (%)	103.9	64.2

[1] **2020 Median Ratios of small non-profit stand-alone hospitals**
[2] S&P Standard and Poors credit rating category (A, and BBB)

Cash Management Key Indicators

- Does your organization measure and monitor these financial ratios?
- How does your organization stack up against these key ratios?
- **Can improvement in revenue cycle performance improve some of these ratios?**

2020 Median Financial Ratios by S&P Rating[1]	A[2]	BBB[2]
Days cash on hand	474.3	273.3
Days in accounts Receivables	49.9	50.7
Cash flow / total liabilities (%)	24.6	16.7
Unrestricted reserves/ long term debt %	354.0	275.2
*Unrestricted reserves/ contingent liabilities %	896.8	787.6
*Contingent liabilities / long-tern debt (%)	61.7	46.1
Long-term debt/capitalization (%)	18.0	20.9
*DB Pension funded status (%)	89.0	99.0
*Pension - adjusted long-term debt / capitalization (%)	18.0	20.3

[1] 2020 Median Ratios of small non-profit stand-alone hospitals
[2] S&P Standard and Poors credit rating category (A, and BBB)

Using Revenue Cycle to Enhance Capital

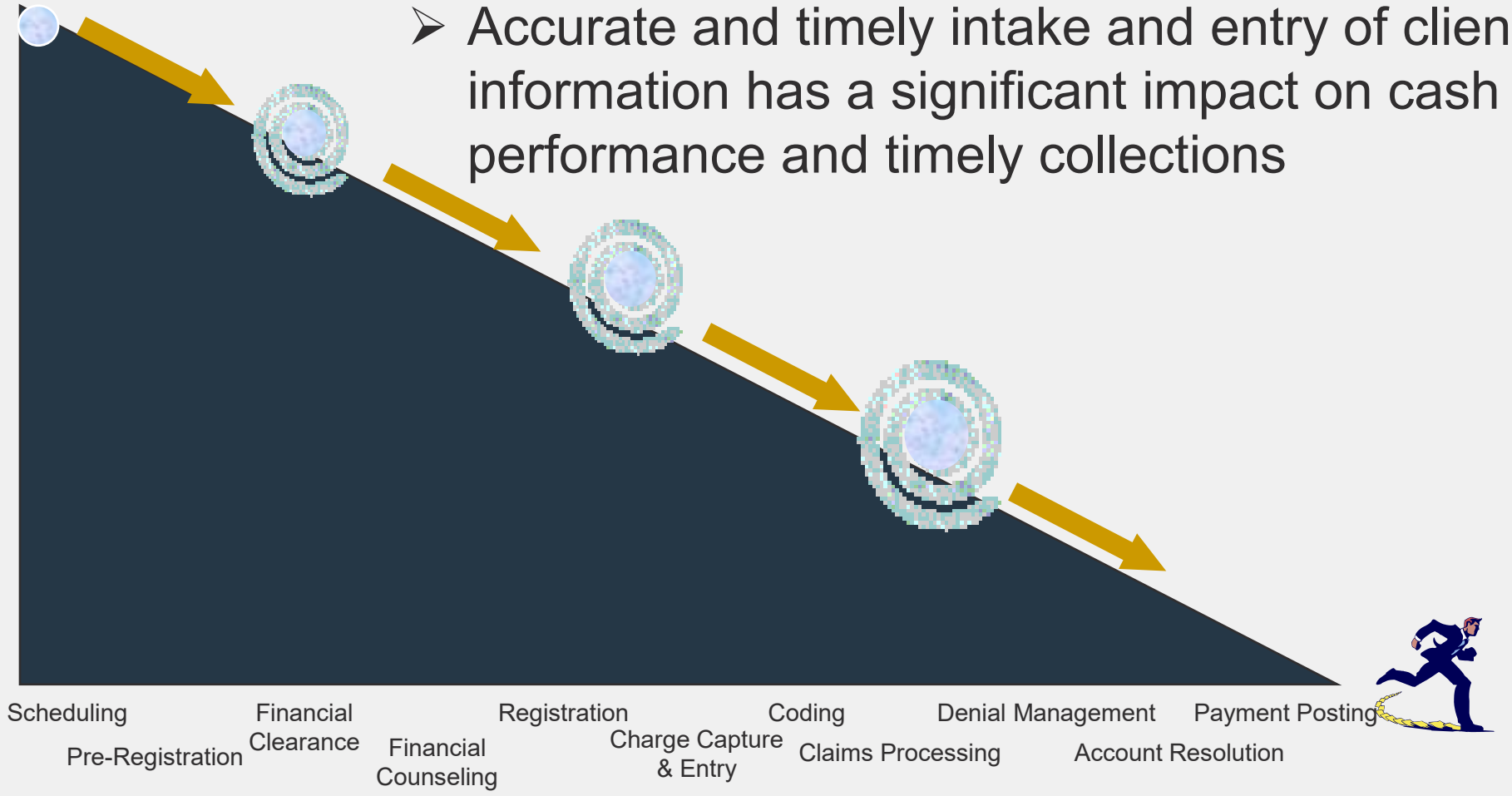
Revenue Cycle Definition

- All **administrative & clinical functions** that contribute to the **capture**, management & **collection** of service **revenue** prior to and/or at time of service

Front- End (Client Intake)		Middle		Back-End	
Client Intake	Admissions / Access: Service Date	HIM/CDI: Coding & CDI	Revenue Integrity: Charge Capture & Pricing	Business Office: Billing	Business Office: Follow-Up
➢ Scheduling ➢ Pre-Registration ➢ Financial Counseling ➢ Medicaid & Charity Application	➢ Registration ➢ Insurance Verification ➢ Pre-Certification / Authorization ➢ Financial Counseling ➢ Staff Deployment	➢ Clinical documentation improvement (CDI) ➢ ICD-10 & HCPCS coding ➢ Medical Records ➢ Cost Report optimization	➢ Charge capture reconciliation ➢ Chargemaster ➢ Pricing rationalization ➢ CDM Standardization ➢ Managed Care pricing / Contracting	➢ Claim submission ➢ Claim Edits & Billing ➢ Electronic billing ➢ Billing backlog reduction ➢ Claim Rejection	➢ Accounts Receivable management ➢ Denials management ➢ Insurance Follow Up ➢ Vendor Management ➢ Cash Posting ➢ Self Pay Collections
<u>Value:</u> Efficient processes to control financial risk, improve accuracy of collection data. Reduced denials from access areas.		<u>Value:</u> Improve net revenue from charge capture, clinical documentation improvement & managed care contracting & pricing.		<u>Value:</u> Improved days in A/R, accelerated cash flow. Reduced cost to collect, bad debt & satisfaction scores from business office processes.	

Why is Front End Revenue Cycle Important

- Accurate and timely intake and entry of client and service information has a significant impact on cash management performance and timely collections

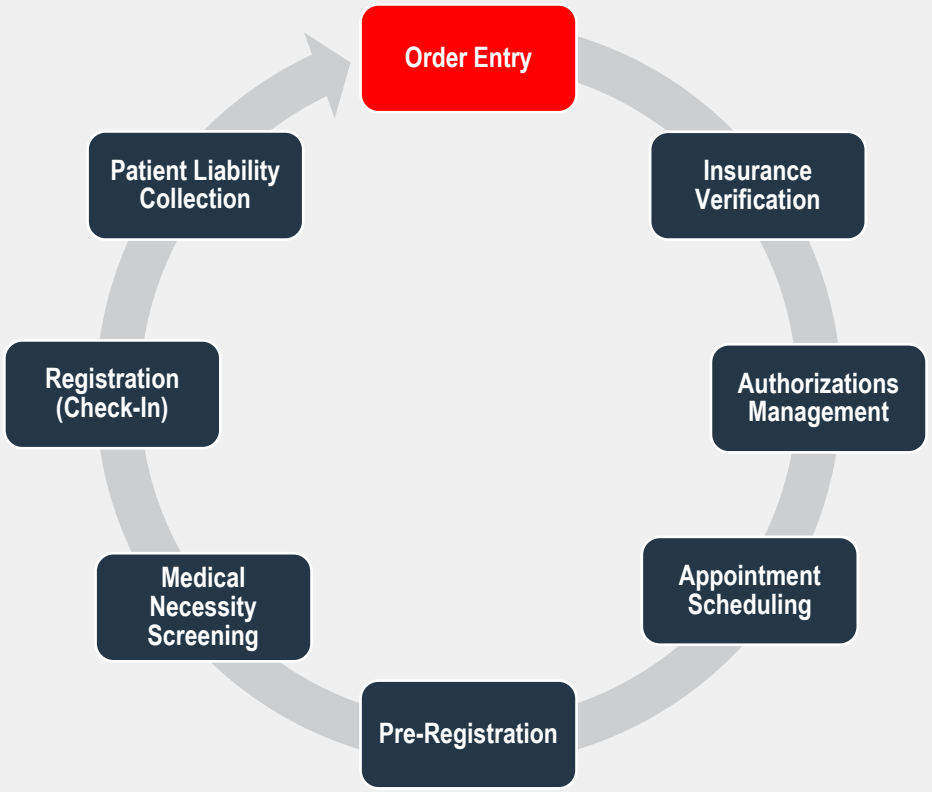


Front End Revenue Cycle Key Elements

- All administrative & clinical functions that contribute to the capture, management & collection of service revenue prior to and/or at time of service

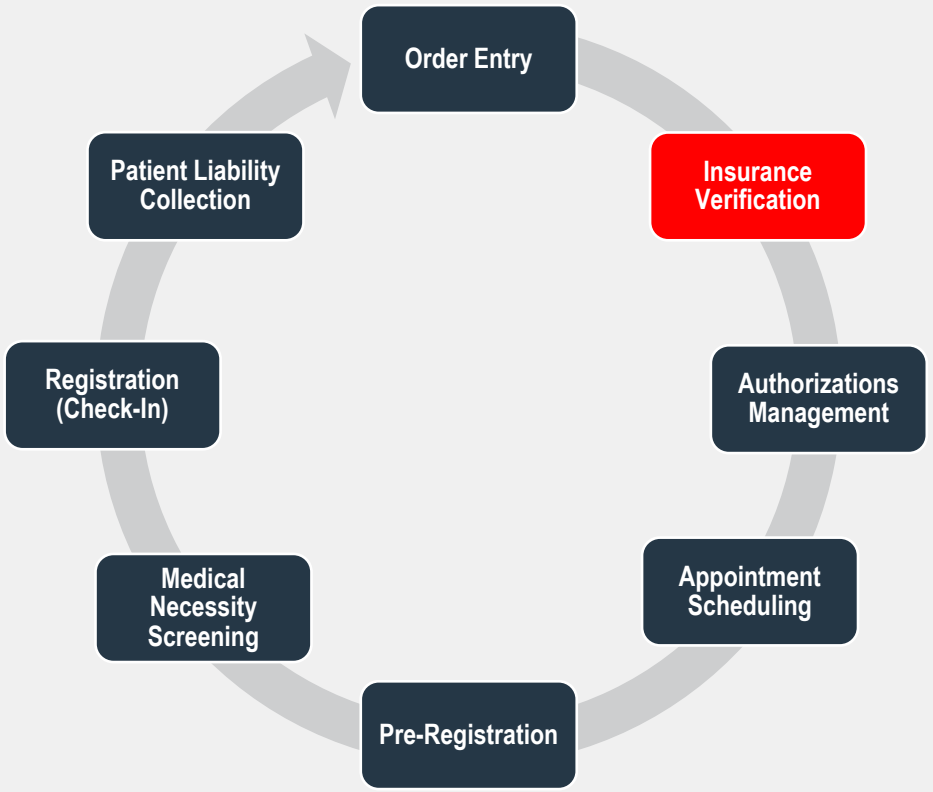
Elements of "Front End" Revenue Cycle Process				
Intake	**Scheduling**	**Pre-Arrival**	Arrival	Financial Counseling
➢ Service Request & Entry ➢ Attaching & Storing Orders ➢ Medical Necessity ➢ Referrals	➢ Receiving/Sending requests to schedule ➢ Entering individual information & Booking Appointments ➢ Relay Instructions ➢ Distributing Appointment or Service Reminders	➢ Entering & resolving individual & order information issues ➢ Insurance, Auth, Medical Necessity, individual demographic verification ➢ Communicating individual liability estimates & referral to F.C.	➢ Check-in & admission process ➢ Entering & resolving individual & order information ➢ Communicating & Collecting individual liability	➢ Determining eligibility & providing enrollment support for assistance programs ➢ Communicate individual liability estimates

Front End Revenue Cycle Best Practices



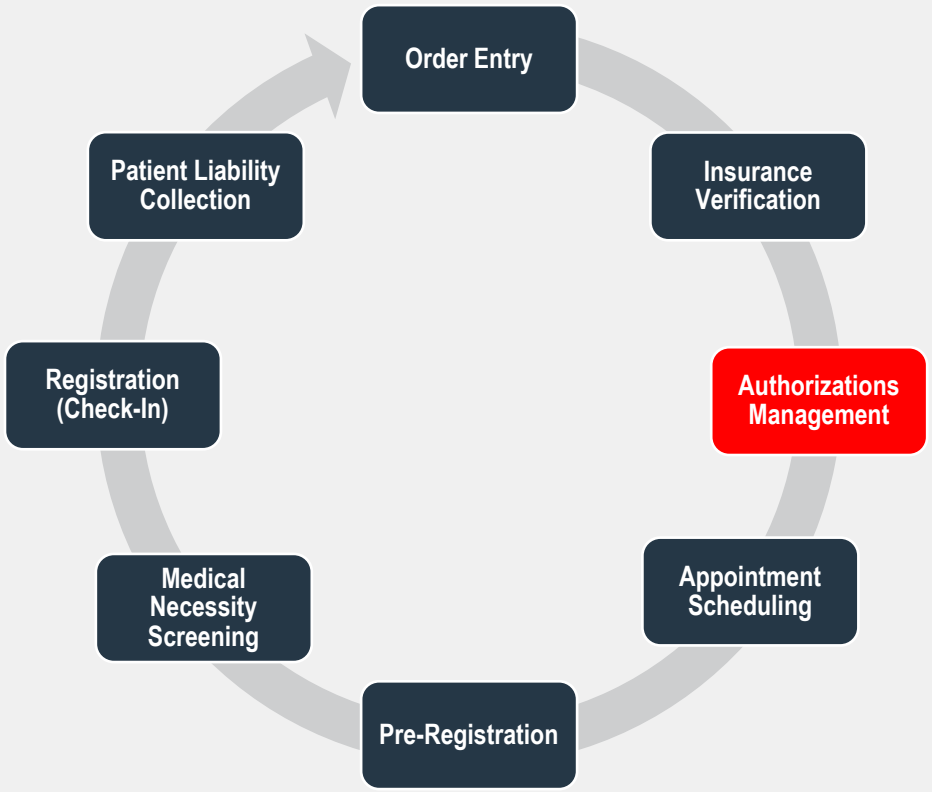
- **Communicate expectations of timely provider order entry** and establish guidance to complete at the end of every encounter and avoid delaying to the end of a shift or day.
- **Establish policy that requires a physician/therapist signature on an order** to confirm appointment booking detail with patients.
- **Implement provider options for priority indicators such as "Routine" and "STAT/Urgent"** to develop dedicated processes to expedite scheduling and when required bypass built-in gatekeepers to flag potential plan authorization requirements.
- **Develop standard order templates that accommodate a description of the service and the corresponding CPT code(s)** to assist downstream efforts around patient liability price estimation.

Front End Revenue Cycle Best Practices



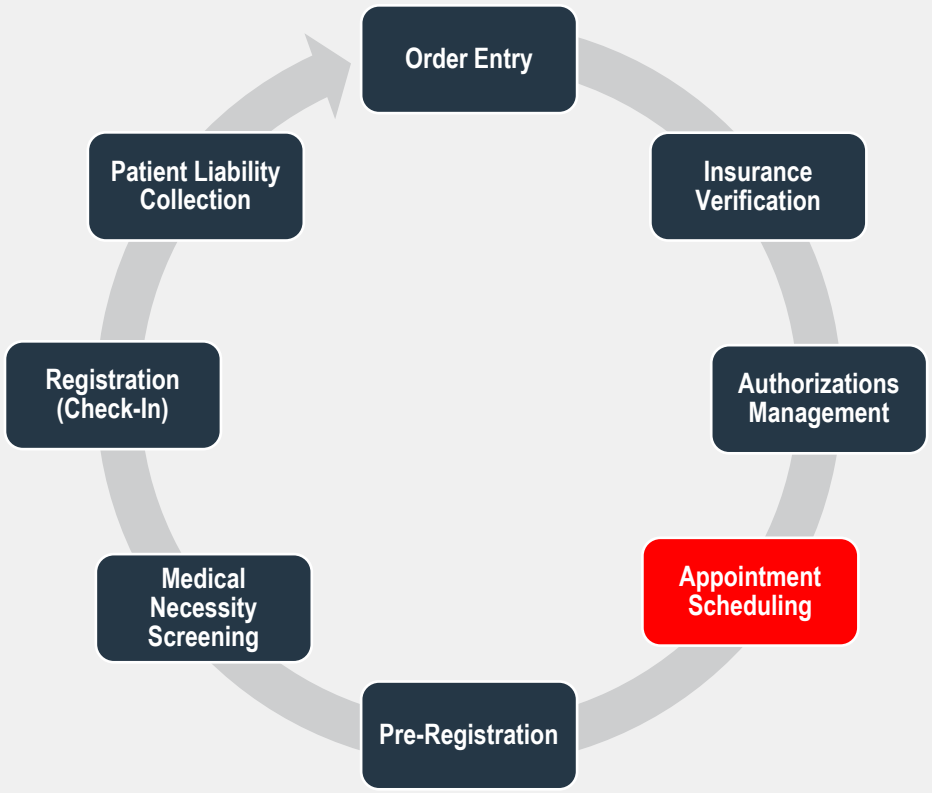
- **Implement a check of insurance eligibility, benefits verification, and coordination of benefits** each time an appointment is scheduled and each time a patient arrives to check-in for a service.
- **Communicate expectations to staff that they should leverage ALL available options to verify insurance** including electronic eligibility software, payer websites, and telephonic outreach, if necessary.
- **Implement "batch launch" eligibility checks for all scheduled appointments to greatly improve the number of insurance plans verified.** Errors that result from the "batch launch" can be populated as an exception-based worklist to be worked by staff in advance of the service.
- **Publish internal guides with screenshots of accepted insurance cards** can assist staff with not only verifying the insurance correctly, but also ensuring the patient is added to the correct financial class.

Front End Revenue Cycle Best Practices



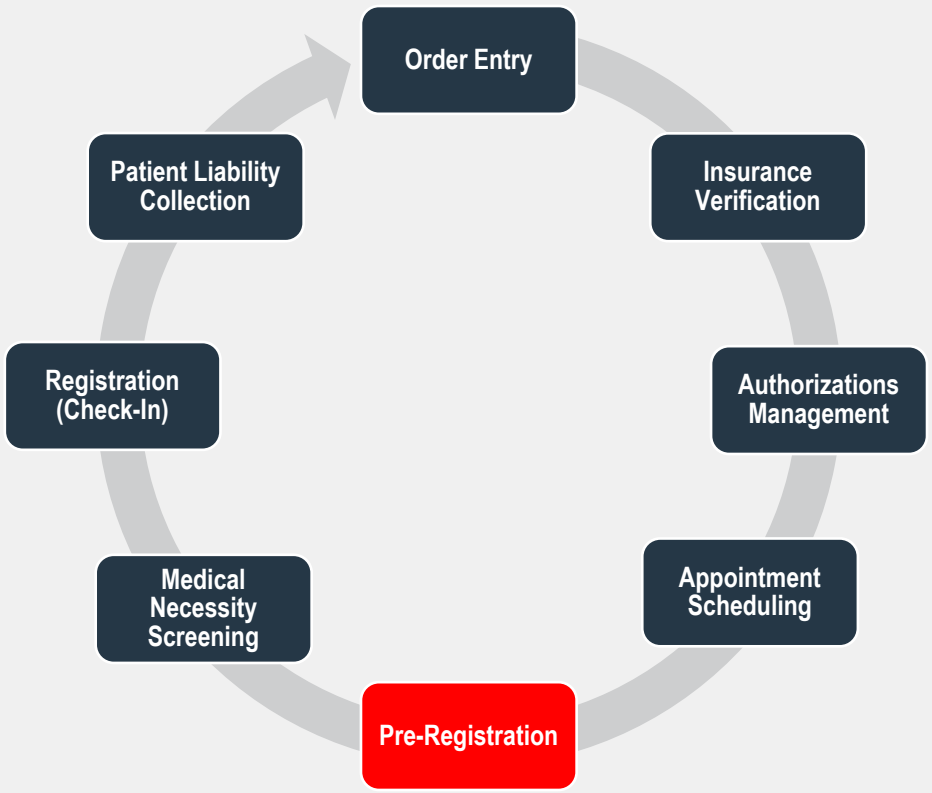
- **Develop an authorization mapping dictionary that crosswalks insurance plans, CPT codes, and authorization requirements.** The dictionary should be maintained and updated continuously as plan changes are identified.
- **Establish policy around authorizations management** that is specific and details exception scenarios for scheduling without authorization (ex: STAT/Urgent priority).
- **Implement account checks on encounters for missing authorizations for denial high risk areas** in order to ensure authorization is on-file prior to claim submission.
- **Trend and analyze missing and/or invalid authorization denials** to identify any potential changes to plan requirements (ex: Expansion of authorization requirement across additional sites of service).

Front End Revenue Cycle Best Practices



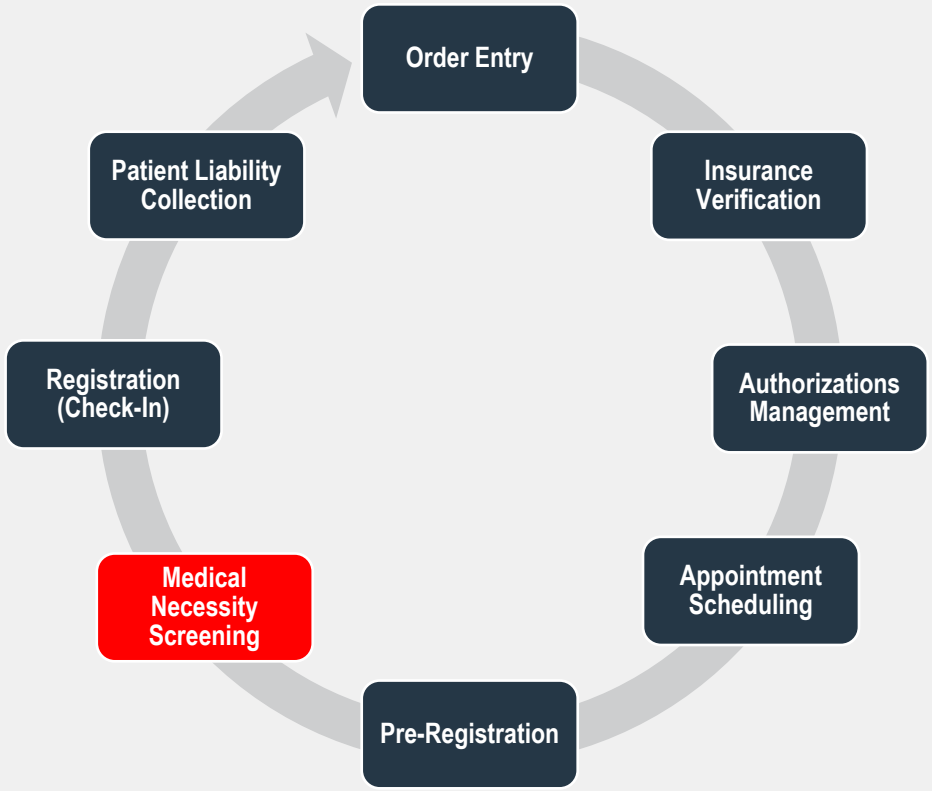
- **Implement minimum scheduling requirements for "Routine" encounters:**
  - Signed provider order on-file
  - Insurance and benefit verification and agreement on co-pay
  - Any plan authorization requirements have been met
- **Establish policy allowing "Urgent" encounters to be scheduled without delay**; however, any authorizations required need to be initiated with the payer prior to end of day on the date of service.
- **Establish policy requiring insurance eligibility verification, communication of liability, or financial assistance approval** where applicable, in order to be scheduled.
- **Trend and monitor appointment realization** which is calculated by dividing the number of appointments rendered over the appointments scheduled over a given period.

Front End Revenue Cycle Best Practices



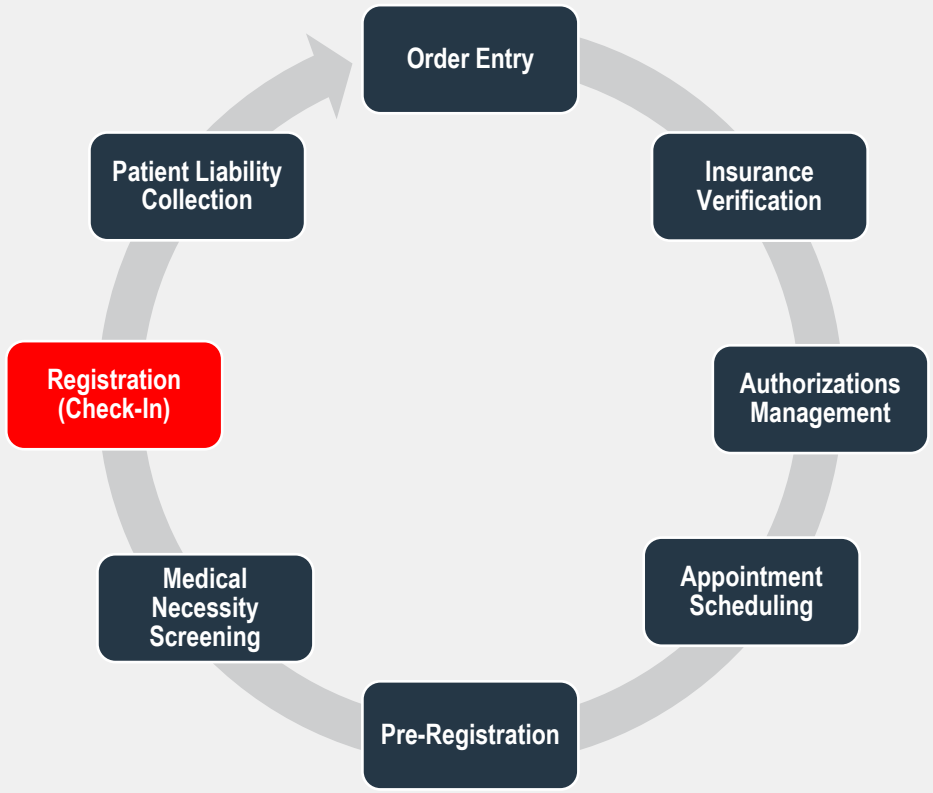
- **Establish pre-registration productivity tracking and monitor performance** against a best practice goal of >94% of scheduled visits pre-registered prior to service.
- **Implement robust staff quality audits and review patient accounts** to ensure accuracy and completeness of pre-registration process.
- **Develop price estimates for all outpatient services** and ask for a minimum deposit for both insured and uninsured patients.
- **Position pre-registration staff to function as a coordinated patient access "safety net"** to ensure all scheduled patients are financially cleared for their upcoming services (ex: Authorization on-file, pre-care collection obtained, financial assistance approved).

Front End Revenue Cycle Best Practices



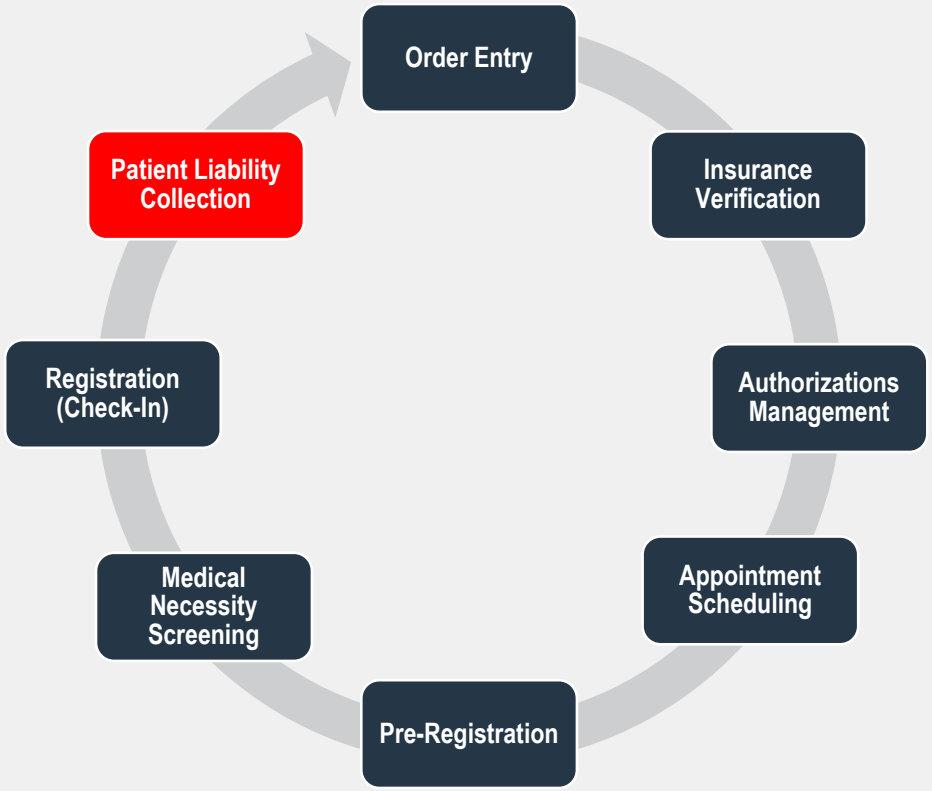
- **Develop a financial clearance process that ensures a check of medical necessity prior to service** with dedicated efforts to ensure they are obtained for affiliated and non-affiliated providers performing I services.
- **Implement rescheduling protocols and assign accountability for all appeals** for services that are initially denied by the payer due to medical necessity.

Front End Revenue Cycle Best Practices



- **Develop comprehensive registration processes for all types of patients and services**
- **Direct registration staff to follow-up on price estimates previously created** and if no collection was made to ask for a minimum deposit for both insured and uninsured patients.
- **Implement robust staff quality audits and review patient accounts** to ensure accuracy and completeness of registration (check-in) process.
- **Establish a financial clearance review at check-in** which requires a check of insurance eligibility, benefits verification, and coordination of benefits.

Front End Revenue Cycle Best Practices



- **Consider phasing in pre-care deposit expectations with price estimates to support collection asks** initially beginning with a narrow set of services
- **Ensure all staff** have the proper system access and training to facilitate point of service collections.
- **Trend and monitor patient cash collection efforts** such as at the point of service and through the pre-registration process to identify areas of improvement.

Front End Revenue Cycle Performance

- Track a few key global performance metrics to monitor success of client intake and front-end procedures .

Metric Name	What is it measuring?	Calculation	Benchmark[1]		
Insurance Verification Rate	How effective the organization is at verifying insurance eligibility	Total Scheduled Encounters with Eligibility Verified / Total Scheduled Encounters	Good: 80%	Better: 90%	Best: 98%

Metric Name	What is it measuring?	Calculation	Benchmark[1]		
Pre-Registration Rate	How effective the organization is at pre-registering scheduled encounters	Total Scheduled Encounters Pre-Registered / Total Scheduled Encounters Available to Pre-Register	Good: 80%	Better: 90%	Best: 95%

Metric Name	What is it measuring?	Calculation	Benchmark[1]		
Point of Service Collections as a % of Patient Cash	How effective the organization is at collecting at the point of service	Point of Service Collections / Total Patient Cash	Good: 30%	Better: 40%	Best: 50%

1. Benchmark metrics provided by National Association of Healthcare Access Management (NAHAM) Access Keys 4.0

Middle Revenue Cycle Key Elements

- A strong middle revenue cycle ensures that services performed are documented and entered accurately and timely

Middle Revenue Cycle Best Practices

- Establish daily charge entry reconciliation process to ensure all charges are capture for services that are scheduled & performed (review against schedule and documentation)
- Establish daily claims reconciliation process to ensure bills have been submitted & received for all services rendered
- Optimize system claim scrubber & coding “edits” to identify & flag common errors for resolution prior to claim submission
- Measure charge entry lag days (days from date of service to charge entry) & develop a prevention plan to reduce or resolve delays impacting timely reimbursement

Middle Revenue Cycle Best Practices

- Conduct regular chart audits to ensure documentation is compliant & maximizing reimbursement

- Hold quarterly meetings to review & update charge description master to eliminate missed charge capture opportunities or billing errors & delays that may be caused by CDM set-up

Middle Revenue Cycle Performance

Measurement	Definition	Calculation	Benchmark
Charge Lag Days	Trending indicator that charges are being entered timely	Average # of days it takes from date of service for charges to be posted or entered into the system *average calculated weekly/monthly	≥3
Coding Productivity	Trending indicator of staff coding productivity	Number of charts reviewed & coded per hour	10-20/hr

Back End Revenue Cycle Key Elements

Elements of "Back End" Revenue Cycle Process			
Billing	Follow Up	Denials	Cash Posting
➢ Claim Creation & Submission. ➢ Claim Edits creation & correction with appropriate departments. ➢ Application of Client Statements Process.	➢ Management & monitoring of outstanding receivables. ➢ Claim Status Inquiries. ➢ Working with payers for delays to claim payment/responses.	➢ Reviewing denial root cause & mitigation needed to address & appeal. ➢ Determination action needed on fatal denials to adjust off appropriately, when required, or adjust to the individual responsibility. ➢ Evaluate underpayments & work with payers when payment terms are not met.	➢ Automatic & manual postings of remittances & reconciliation to bank deposits. ➢ Application of payments & adjustments for appropriate individual balances. ➢ Month end reconciliation & reporting.

Billing and AR Collections Best Practices

Billing

- Stratify accounts by amount
- Separate accounts by financial class
- Define & develop policies & procedures for billing guidelines
- Educate staff on:
  - Payer Contract Requirements
  - How to verify insurance coverage
  - Payer Specific billing requirements
- Monitoring timely filing of claims in accordance with payer requirements

Follow Up / Denials

- Design a team of individuals to appeal denials for reconsideration of payments
- Prioritize insurance AR follow up based on $ and risk of timely filing limit if needed
- Ensure all outstanding claims are reviewed every 30 days
- Develop, implement & monitor performance of appeals for denials received & appeal success rates
- Monitor denials for reporting & resolution by:
  - Payer
  - Denial Type
  - Reason
  - Root Cause
  - Appeal Success Rate
- Monitoring timely filing of claims in accordance with payer requirements for appealing claims

Claim Submission and Payment Review Best Practices

Claim Errors and Manual Billing Submission

- Claim edits set up in the billing scrubber should be reviewed against denials data to determine if additional edits can be created to resolve errors prior to bill submission
- Patient accounting system insurance plans should be reviewed against billing scrubber logic to ensure claims are being routed to the correct location
- Bridge routines should be reviewed to determine if components of billing process such as bundling of charges can be automated

Collections Follow Up

- Staff Insurance collection worklists should be prioritized based on account value and days from payer timely filing limits
- Clinical insurance denials should be appealed to the fullest extent possible including involvement of a physician if needed
- Insurance payer processing issues should be logged, tracked, and communicated to a formal insurance representative regularly

Payment Variance

- Insurance contracts should be loaded into the system and reporting should be created to identify and track accounts that are overpaid or underpaid
- A vendor or team should be assigned to specifically work underpaid and overpaid accounts
- A vendor or team should be assigned to perform an additional review of zero balance (adjusted) accounts for missed collection opportunity

Denial Prevention Best Practices

- Healthcare organizations can lose 3% or more of net revenue due to preventable issues (denials)
- Does your organization measure denials or have denial related reporting?
- Does your organization have specific adjustment and GL codes for insurance denial write-offs?

DENIAL STEERING COMMITTEE STRUCTURE

DENIAL ANALYTICS AND REPORTING

DENIAL ROOT CAUSE ISSUE IDENTIFICATION

DENIAL PREVENTION AND MANAGEMENT STRATEGY

PROJECT MANAGEMENT AND CONTINUOUS PROCESS IMPROVEMENT

How to Determine if a Claim Denied

- Standardized Claim Remittance Adjustment Reason and Group Codes Help Identify Why and How a Claim was Denied:
  - **Group Codes: Group codes identify the financially responsible party or the general category of payment adjustment.**
    - CO – Contractual obligation (means provider is liable for any remaining balance on claim)
    - PR – Patient responsibility (means provider may bill the patient for the outstanding balance)
    - OA – Other adjustment (means balance cannot be billed to the patient and provider isn't liable)
    - PI - Payer Initiated Reductions (means payer is adjusting the responsibility of the patient because there is no supporting contract between the provider & payer)
  - **CARC: Claims Adjustment Reason Codes**
    - 50- These are non-covered services because this is not deemed a 'medical necessity' by the payer.
    - 119- Benefit maximum for this time period or occurrence has been reached.
  - **RARC: Remittance Advice Remark Codes**
    - M97- Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
    - N56- Procedure code billed is not correct/valid for the services billed or the date of service billed.

Sample Denial

Reason/Remark Summation

Group/ Reason Code	Amount	Units	Description
PR31	145.00	1	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

Remark Code	Description
MA01	ALERT: IF YOU DO NOT AGREE WITH WHAT WE APPROVED FOR THESE SERVICES, YOU MAY APPEAL OUR DECISION. TO MAKE SURE THAT WE ARE FAIR TO YOU, WE REQUIRE ANOTHER INDIVIDUAL THAT DID NOT PROCESS YOUR INITIAL CLAIM TO CONDUCT THE APPEAL. HOWEVER, IN ORDER TO BE ELIGIBLE FOR AN APPEAL, YOU MUST WRITE TO US WITHIN 120 DAYS OF THE DATE YOU RECEIVED THIS NOTICE, UNLESS YOU HAVE A GOOD REASON FOR BEING LATE.

Denial Data Examples

Rejection Data

Billing Scrubber Import Error Data Description	Total 08.19-09.19	% of Total
ANSI %1 : When billing Type of bill xx7 or xx8 (or Medicare xxQ), the ICN/DCN or original payer control number is required and vice versa.	6654	6%
Payer being billed: Outpatient claims with a surgical HCPCS (%1) require an Operating Physician unless a Principal diagnosis indicating the procedure was not carried out is present.	5350	5%
NCCI: HCPCS %4 is a Column 2 code and may not be billed with Column 1 HCPCS %3 on the same date of service. %9	4072	4%
Billing SEC/TER Payer: Adjudication Information for prior payer %1 is required in the Payer Info or COB Data attachment. Claim does not contain required CAS segments.	3427	3%
Payer-being-billed: Modifier %1 is invalid for the service dates. Please review for a more appropriate modifier.	3164	3%
Medicare: TOB xx7 requires a Condition Code D0- D4, D7- D9, or E0 and vice versa. Condition Code D5 and D6 are not allowed with TOB	2849	3%
ANSI : (LINE#%L) The Service Date cannot be before the Statement From Date nor after the Statement Thru Date.	2441	2%

Denial Data

Stmt Thru	PT Type	Claim Status	Adj Reason Cat	Reason	Payer	ERA Pay Date	Remark	Charge Amt	ayment Amt	nied Amou
9/30/2019	OP Obs	Processed as Primary	Non-Covered	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	JM MAC SC/HHH-PALMETTO GBA #11001	10/24/2019	y excluded	$69.00	$0.00	$69.00
9/30/2019	OP	Denied	Eligibility/Registration	26 - Expenses incurred prior to coverage.	JM MAC SC/HHH-PALMETTO GBA #11001	10/11/2019	he patient	$11.00	$0.00	$11.00
9/30/2019	OP	Denied	Eligibility/Registration	26 - Expenses incurred prior to coverage.	JM MAC SC/HHH-PALMETTO GBA #11001	10/11/2019	he patient	$155.00	$0.00	$155.00

Write-Off Data

Acct #	ACCT END DT	ACCT START DT	ATTN PROVIDER NAME	BKD Write-Off Category	Facility	Insurance	Post Date	Service Location	Transaction Description	Write-Off Amount
999999	5/27/2016	5/27/2016	LDSTEIN, WILLIAM MCCA	Timely Filing	MCDI	M97	10/2/2017		UNTIMELY FILING	$4,065
999999	8/18/2016	8/18/2016	GULYANICH, TARAS M	Medical Necessity	MCDI	L26	10/2/2017		NOT MEDICALLY NECESSARY ADJ	$5,319
999999	9/15/2016	9/15/2016	BROWN, MICHAEL N	Timely Filing	MCDI	H50	10/2/2017		UNTIMELY FILING	$460
999999	2/24/2017	2/24/2017	CUNNINGHAM, KIEVERS L	Medical Necessity	MCDI	M55	10/2/2017	EMERGENCY DEPAR	NOT MEDICALLY NECESSARY ADJ	$10,744
999999	3/15/2017	3/9/2017	MITCHELL, BENJAMIN T II	Authorization	MCDI	310	10/2/2017	MEDICINE-GENERAL	NO AUTH/PRE CERT CONTRCTUAL	$8,408

How to Measure Denial Performance

- Measure claim remittance denial rate and write-offs as a % of net patient service revenue
- Set reduction targets by reason category based on opportunity to prevent future denial write-offs and resource allocation

REMITTANCE DENIAL RATE (AR-5)

Purpose:

Trending indicator of % of claims denied.

Value:

Indicates provider's ability to comply with payer requirements and payers' ability to accurately pay the claim; efficiency and quality indicator.

Equation:

Total number of claims denied = Accounts Receivable[1]
Total number of claims remitted 835 Files and/or Paper Remittance

1 Billed A/R = electronic 835/paper source as remit

Points of Clarification:

Number of Claims Denied

Total claims adjudicated monthly at claim level. Denials are defined as "actionable denials" - those denials that may be addressed and corrected within the organization and may result in appropriate reimbursement.

DENIAL WRITE-OFFS AS A PERCENTAGE OF NET PATIENT SERVICE REVENUE (AR-6)

Purpose:

Trending indicator of final disposition of lost reimbursement where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount.

Value:

Indicates provider's ability to comply with payer requirement and payer's ability to accurately pay the claim.

Equation:

Net dollars written off as denials = Patient Financial System
Average monthly net patient service revenue Income Statement

Points of Clarification:

Net Dollars Written Off As Denials

Total dollars written off as a denial in the reporting month, net of recoveries

Includes:

- Denied RAC dollars resulting from lost appeals or choosing not to appeal
- Dollars must be stated at net
- Only payments containing a denial code on the remittance advice[1]

Excludes:

- Denials for plan excluded (non-covered) services
- Denials for patient responsibility

Denial Prevention Best Practices

- **Categorize and trend your denial (bad debt) write-off codes** from insurance denials into category and measure month over month
- **Set reduction targets by reason category** based on opportunity to prevent future denial write-offs and resource allocation

		Annualized Reduction Target		
		25%	35%	45%
Denial & Avoidable Write-Off	Baseline Write-Off ($M)	Conservative ($M)	Moderate ($M)	Aggressive ($M)
Timely Filing Denial Adjustment	**$3.2**	$0.8	$1.1	$1.4
Non-Covered Denial Adjustments	**$8.4**	$2.1	$2.9	$3.8
Authorization Denial Adjustments	**$7.8**	$2.0	$2.7	$3.5
Clinical/Coding Denial Adjustments	**$2.3**	$0.6	$0.8	$1.0
Medical Necessity Denial Adjustments	**$5.0**	$1.3	$1.8	$2.3
Late Charge Adjustments	**$1.0**	$0.3	$0.4	$0.5
Total	$27.7	**$6.9**	**$9.7**	**$12.5**

Denial Prevention Best Practices

- **Review and analyze** initial insurance claim denials and system data to pro-actively identify denial trends before they turn into write-offs or additional re-work

	03/2021 - 08/2021 Initial Claims Annualized			
Denial Category [1]	**Denied Amount ($)**	**Denied Amount (%)**	**Number of Claims (#)**	**Number of Claims (%)**
Additional Documentation Needed	$36,601,830	37.3%	39,380	27.7%
Authorization	$12,078,412	12.3%	9,770	6.9%
Billing Error	$10,974,548	11.2%	13,812	9.7%
Coordination of Benefits	$8,537,575	8.7%	20,742	14.6%
Eligibility/Registration	$6,182,557	6.3%	13,190	9.3%
All Others	$23,644,777	24.1%	45,480	31.9%
Total	**$98,019,699**	**100.0%**	**142,374**	**100.0%**

Denial Committee Structure

- **Representation across functional areas and departments** as root cause issues and solutions involve cross-departmental solutions
- **Establish ownership and responsibilities** including leadership to help drive the change and process owners to implement change

Revenue Cycle Staff

Patient Access
Billing
Coding/HIM
Denials

Clinical Staff

Physician Champion
Service Line Leaders
Pharmacy

Support staff

IT
Managed Care
Quality

Denial Prevention Best Practices

- **Set clear expectations** including ownership of reporting, meeting attendance expectations and other administrative items needed for success
- **Establish overall vision and strategy** so everyone is aligned on the organizational goals

A Purpose of the Hospital Denials Management Committee

Primary Functions

The primary function of the Denials Management Steering Committee is to provide oversight of Denial Management and Denials Prevention activities for Ryan Health. The Denials Management Steering Committee will monitor and review the overall denial metrics establish performance goals for Ryan Health and provide oversight and direction to the Denials Management function for the Ryan Health hospitals and physician groups. .

The Denials Management Steering Committee provides a direction so organizational concepts are established and maintained with a visionary view. The Denials Steering Committee provides insight on long-term strategies in support of operational, compliance, and financial goals of Ryan Health. In practice these responsibilities are carried out by performing the following functions:

- Facilitate vision & strategy setting
- Monitor execution of strategy, results and return on investment
- Communicate with Ryan Health leadership, Hospital Administrators and Physician Groups
- Monitoring and review of Hospital Denials Management Committee projects and at regular Steering Committee meetings;
- Providing direction to the Hospital Denials Management Committees;

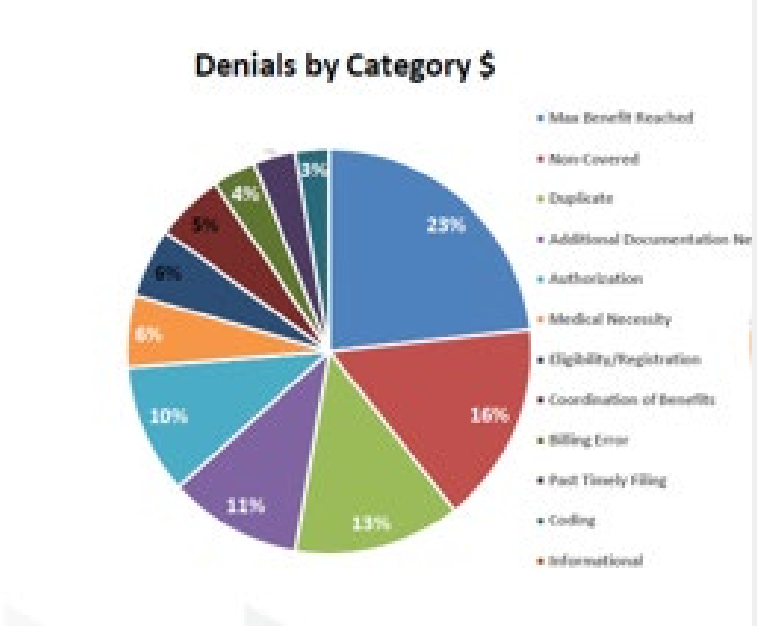
Responsibilities

The Denials Management Steering Committee has advisory responsibilities including:

- Prioritization of objectives and projects for Ryan Health Revenue Cycle teams and Hospital Administrators
- Providing guidance on development and sharing of necessary tools for Hospitals and departments to track, monitor and address root causes of Denials
- Champion Denials Prevention initiatives
- Establishing system wide goals and target metrics for Denials
- Work with appropriate departments to assure development of policies and procedures to improve billing compliance and reduce denials
- Oversee communication plans to Ryan Health personnel regarding denials management procedures and trends
- Ensure open communication between departments and among Hospitals regarding Denials Management issues and trends

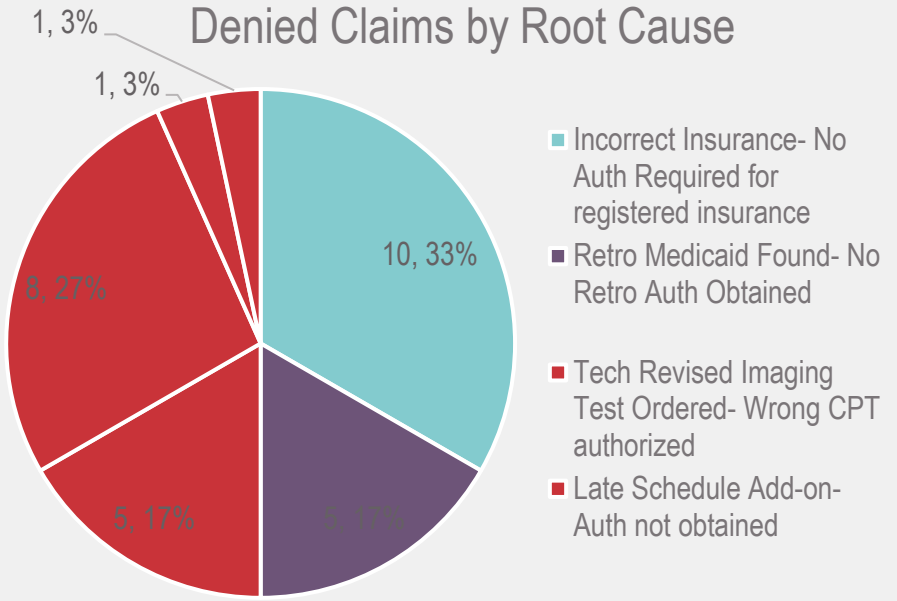
Denial Prevention Best Practices

- **Identify global trends** within denial data across all clinics, payers, and procedure categories (G-Code and re-imburseable clinic codes), denial $, and denial volumes
- **Identify fatal claim denials** that are typically resulting in write-offs for the organization
  - **Drill into more specific detailed trends once top issues are identified** (ex: majority of authorization denials are for Dr. Smith and Blue Cross)



Denial Prevention Best Practices

- Sample insurance denied claims and write-offs to identify key root cause issues driving high volume and $ issues
- What are the big denial trends your organization is seeing?
- What are the root cause issues driving denials (ex; lack of staff training and education, payer processing error, IT system interface issue, lack of standard policies and procedures)?



Denial Prevention Best Practices

- **Set clear expectations** including ownership of reporting, meeting attendance expectations and other administrative items needed for success
- **Establish overall vision and strategy** so everyone is aligned on the organizational goals

Primary Denial Category	Facility Impacted	Denial Reduction Initiative Summary	Status	Initial Start Date	Target Completion Date	Primary Task Owner	Task Manager	Estimated Total Hours/Month	Status Comments	January 19' Action Items
All		-Developed, implemented and provided instructional training on denials reporting (Tableau dashboard) -Additional dashboard (thermometers) for financial measurement being shared with adminsitrators	Ongoing	04/18	N/A			16	Financial and Detail Denial Dashboards Populated and Distributed Monthly. Additional Users and Training Performed as Needed	1. Population and Distribution of Dashboards to leadership and manager list- Completed for December
Authorization		Developed enhanced reporting and tracking process for Oncology/hematology staff obtaining authorizations; Revisions to IVT authorization obtainment process including conversion to electronic "jelly bean" request process, tracking log, and additional resource to help with volume inflow	In Progress	07/18	02/28/19			16	Follow up step to mirror process at other facilities (if applicable). Continued bi-weekly meetings to discuss any reporting or issues related to authorization process	1. Ryan R. holding weekly update and issue meetings with MOHA authorization staff
Authorization		Spread of item number 2 to Seacoast	In Progress	07/18	02/28/19			4	Follow up step to mirror process at other facilities (if applicable). Determine owner at Seacoast	1. Determine Owner of process at SeaCoast as restructuring may have impacted who to work with - Owner will be Christ Hurst 2. Determine timeline and reach out to Neil (SCI) for report creation
Authorization		Implemented "End of Day" incomplete report and process used by scheduling to identify, communicate, and work cases scheduled for next day without a valid authorization	Ongoing	08/18	N/A			16	Process in effect; tweaked by Kandy from BKD initial implementation. Need to set up meeting with MPA to discuss communciation and feedback loop	1. Kandy performing modifications to report to work earlier and monitoring daily to ensure completion/progress is being made 2. Determine MPA leader and set up meeting to discuss providing routine feedback to MPA for prevention of late or missed authorizations

Denial Management Best Practices

- **Standardize insurance appeal letter templates**
- **Standardize follow up notes and write-off codes**
- **Prioritize** accounts receivable based on risk and value
- **Create a denial management team and routing structure**
- **Automate** follow up tasks

Why is Cash Posting Important

- Automating and moving to electronic based cash posting process can reduce administrative costs considerably for your organization!
- Cash Posting issues often impact billing, accounts receivable days, accurate financial reporting and many other areas (hidden cost of bad posting and reconciliation procedures)

Provider Resources per Claim	*Paper Check* + *Manual Remit*	*Electronic Payment* + *Manual Remit*	*Paper Check* + *Electronic Remit*	*Electronic Payment* + *Electronic Remit*
Payment Processing Time & Cost	5 minutes **$2.51**	3 minutes **$1.51**	5 minutes **$2.51**	3 minutes **$1.51**
Remittance Processing Time & Cost	7 minutes **$3.76**	7 minutes **$3.76**	2 minutes **$1.21**	2 minutes **$1.21**
Resources per Claim	12 minutes **$6.27**	10 minutes **$5.27**	7 minutes **$3.72**	5 minutes **$2.72**
Cost per 7500 Claims	**$47,025**	**$39,525**	**$27,900**	**$20,400**

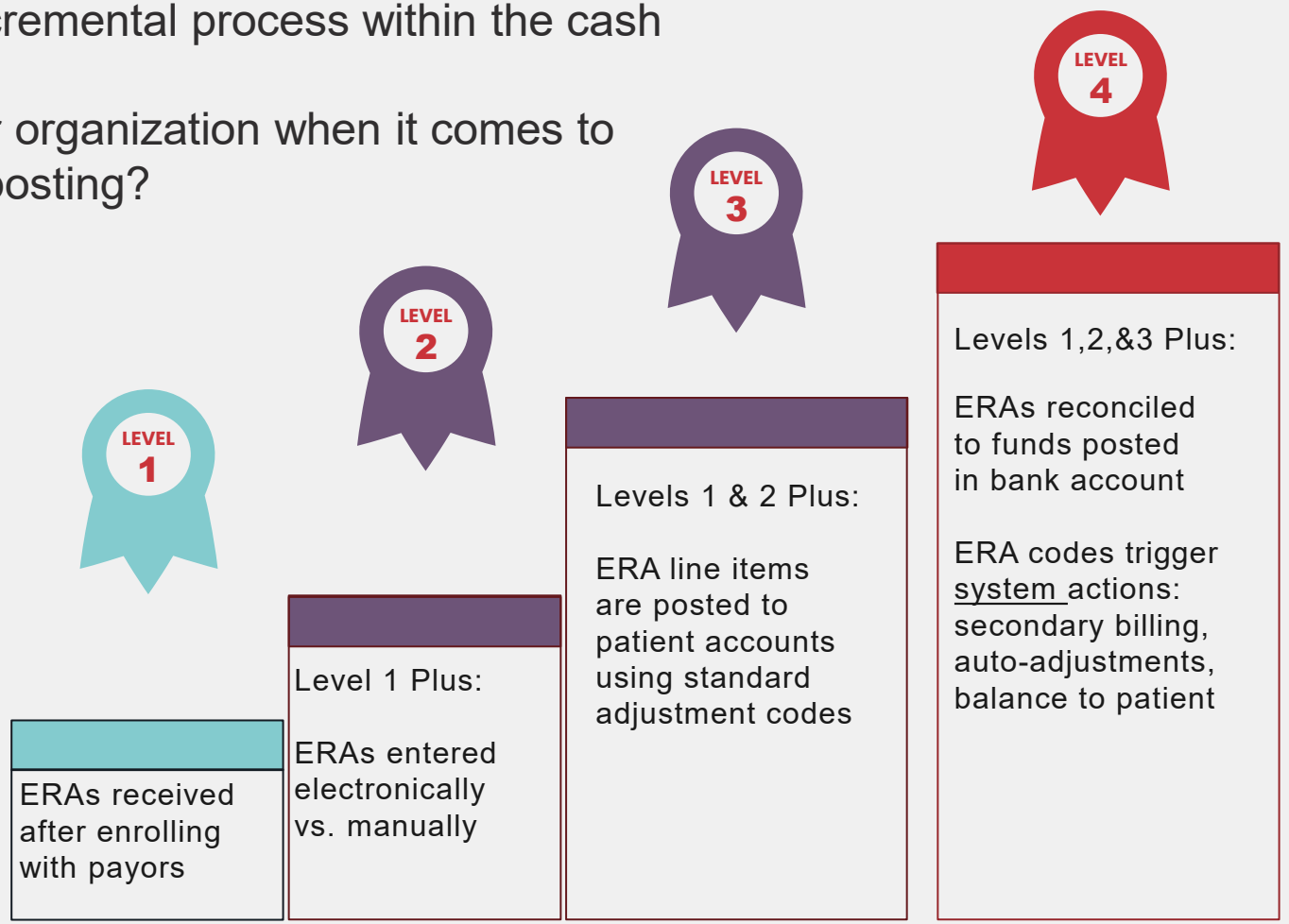
Cash Posting Best Practices

- Overall improvement goals are increased automation, visibility into adjustment detail, and reconciliation to make sure all deposits and remittances are accounted for in the patient accounting system

Deposit Reconciliation	Remittance & Deposit Matching	Application of Payments & Adjustments	Month End & GL Reporting
Daily Deposit: All Items Recorded in Patient Accounting System	Each Verified Deposit Matched to a Remittance • Lockbox • Electronic • Retrieved from Payor Portals • Mail	Remittance Details Recorded in Patient Accounting System • Claim Totals • Zero-Payments	Month Ending Bank Deposit Total = Posted Amounts • Unposted Cash Tracking

Cash Posting Best Practices

- Improvement is an incremental process within the cash posting function
- How electronic is your organization when it comes to cash and remittance posting?



Source: HFMA

Small Changes = Big Wins

Revenue Cycle Key Performance Indicators

Key Performance Indicator	Definitions	Top Quartile	Associated Watch Metrics/Items
Pre-Registration Rate	Trending indicator that patient access processes are timely, accurate, and efficient, measures scheduled encounters that are pre-registered	≥ 98.00%	• End-User Registration Quality Audit Scores • Eligibility Check Lead Time (to DOS)
POS Collection % of Patient Cash	Trending indicator of point-of-service collection efforts, indicates potential exposure to bad debt, accelerates cash collections, and can reduce collection costs, excludes refunds and routine payment plan payments unless collected at time of service	≥ 40.00%	• Price Estimator Accuracy • Available vs. Collected Rates
Late Charges % of Total Charges	Measure of revenue capture efficiency, helps identify opportunities to improve revenue capture, reduce unnecessary cost, enhance compliance, and accelerate cash flow	≤ 0.50%	• 100% Daily Department Charge Reconciliation
Aged A/R >90 Days % of Total Billed A/R	Trending indicator of receivable collectability, indicates revenue cycle effectiveness at liquidating A/R, excludes: active billed credit balance accounts; Discharged Not Final Billed (DNFB) accounts; in-house accounts; in-house, interim-billed accounts	≤ 16.90%	• Daily Account Resolved (45 – 60 per FTE) • Daily Cash Posting & Reconciliation per FTE
Denial Write-Offs as % of Gross Revenue	Trending indicator of final disposition of lost reimbursement, where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount, indicates provider's ability to comply with payer requirement and payer's ability to accurately pay the claim	0.51%	• Appeal Success Rate (Pre & Post-Bill) • Number of Claims Within 30 Days of Timely Filing • Aged DNFB • Daily Denials Resolved per FTE (45 – 60 per FTE)

Revenue Cycle Key Performance Indicators

Revenue Leakage Metrics	Hospital	Ntnl. Benchmark	Variance
Charity Write-Off % of Gross Revenue	0.15%	2.60%	*+2.5%*
Denial Write-offs % of Gross Revenue	0.18%	0.60%	*+0.4%*
Initial Denials % of Gross Revenue	10.3%	6.55%	*-3.8%*
Actionable Initial Denials % of Gross Revenue	7.3%	6.55%	*-0.8%*
Patient Access Metrics			
Point of Service Collections % of Total Pt. Cash	21.6%	40.0%	*-18.4%*
Pre-Registration Rates	Not Reported	94%	N/A
Insurance Verification Rates	Not Reported	95%	N/A
Clinical & Mid-Revenue Cycle Metrics			
Average Charge Lag	1.6 Days	3.0 Days	*+1.4%*

APPENDIX

Denials Prevention Dashboard Example (1/3)

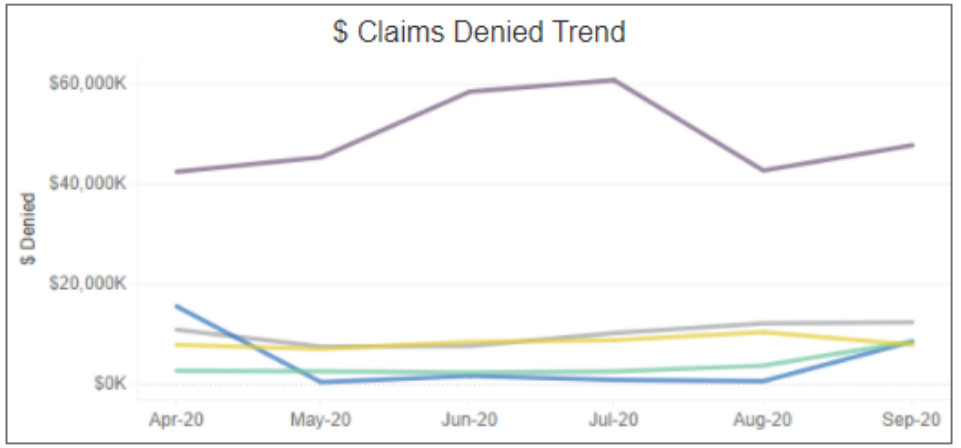
[redacted] Denials Management

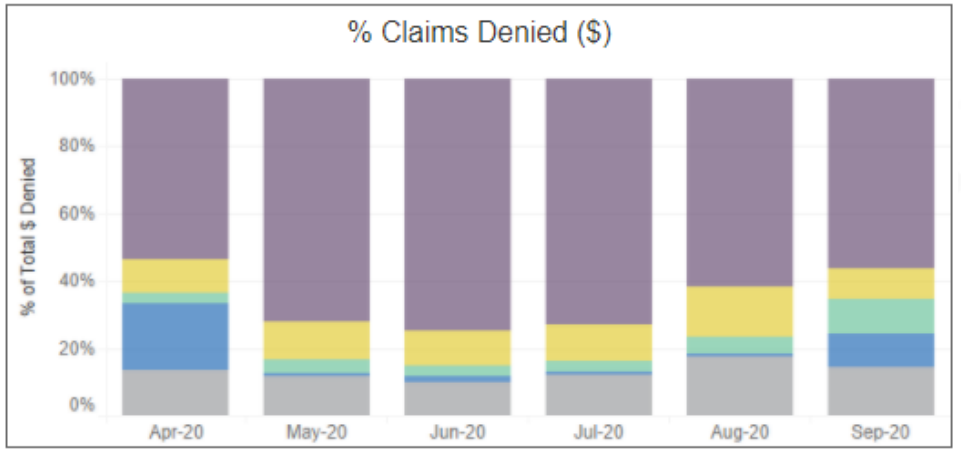
Each of the dropdown boxes below can be changed to break the denials information based on your needs. The default is to group all by Location, but you can easily change the dropdown boxes to also break by Financial Class, Payer, Denial Reason Category, Procedure Category, and/or Procedure.

Filters | Home | Denial Summary | Claim Denial Details | User Guide & Reconciliation

Showing Remits from April 2020 thru September 2020

Location	---SELECT---	---SELECT---	---SELECT---	---SELECT---	# Denied	% of Total # Denied	$ Denied	% of Total $ Denied
Overall					66,341	100.0%	$458,328,930	100.0%
Arthur Hospital					2,724	4.1%	$15,455,926	3.4%
Burgess Hospital					26,980	40.7%	$297,653,771	64.9%
Cisco Behavioral Health H..					66	0.1%	$1,324,154	0.3%
Holiday Hospital					2,733	4.1%	$15,949,213	3.5%
Other					17,688	26.7%	$17,563,354	3.8%
Parks Hospital					3,168	4.8%	$22,243,736	4.9%
Parrish Hospital					523	0.8%	$27,459,119	6.0%
Regan Hospital					12,459	18.8%	$60,679,658	13.2%





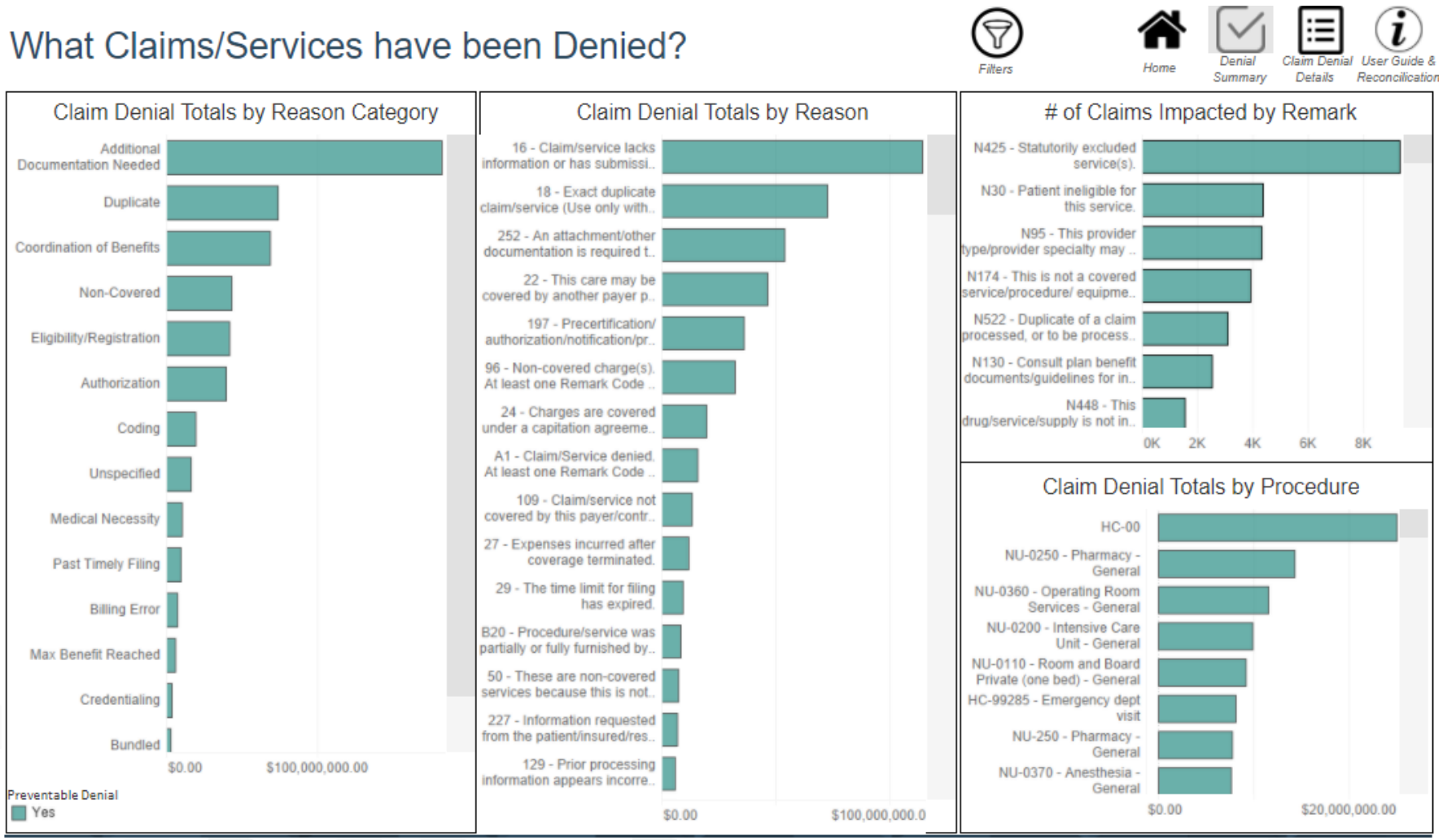
Legend Claims Denied ($)

Burgess Hospital | Parks Hospital | Regan Hospital | Other | Parrish Hospital

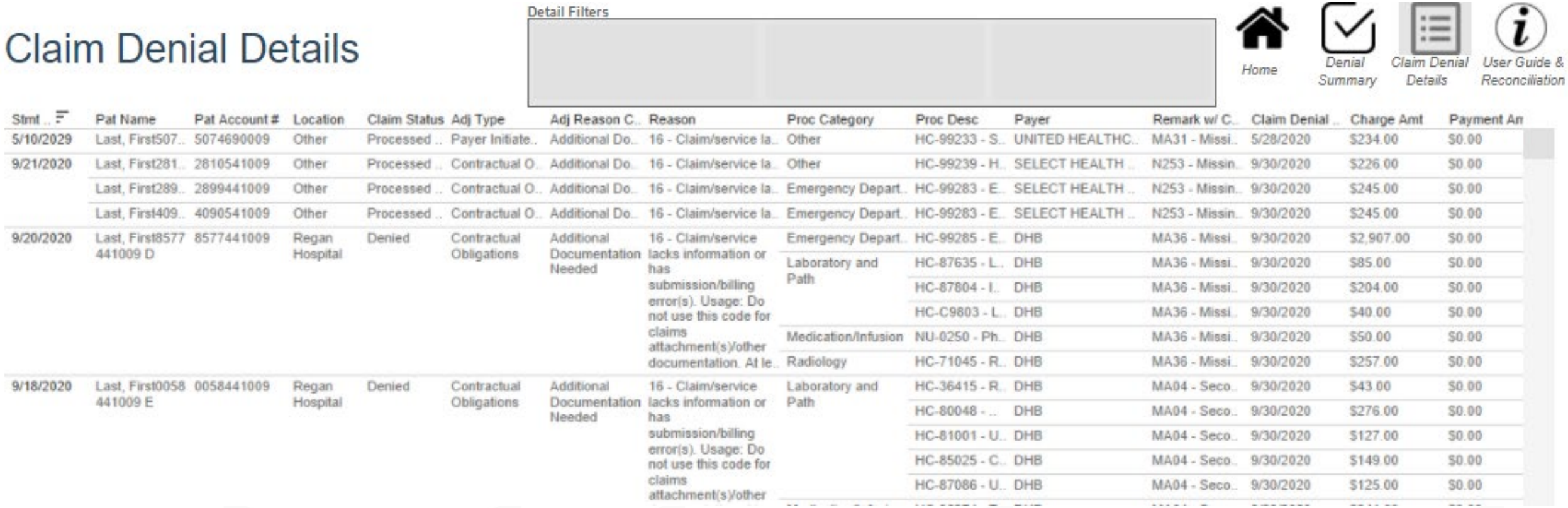
Data Last Updated:

BKD

Denials Prevention Dashboard Example (2/3)



Denials Prevention Dashboard Example (3/3)



Claim Denial Details

Detail Filters

Home | Denial Summary | Claim Denial Details | User Guide & Reconciliation

Stmt ..	Pat Name	Pat Account #	Location	Claim Status	Adj Type	Adj Reason C..	Reason	Proc Category	Proc Desc	Payer	Remark w/ C..	Claim Denial ..	Charge Amt	Payment An
5/10/2029	Last, First507..	5074690009	Other	Processed ..	Payer Initiate..	Additional Do..	16 - Claim/service la..	Other	HC-99233 - S..	UNITED HEALTHC..	MA31 - Missi..	5/28/2020	$234.00	$0.00
9/21/2020	Last, First281..	2810541009	Other	Processed ..	Contractual O..	Additional Do..	16 - Claim/service la..	Other	HC-99239 - H..	SELECT HEALTH ..	N253 - Missin..	9/30/2020	$226.00	$0.00
	Last, First289..	2899441009	Other	Processed ..	Contractual O..	Additional Do..	16 - Claim/service la..	Emergency Depart..	HC-99283 - E..	SELECT HEALTH ..	N253 - Missin..	9/30/2020	$245.00	$0.00
	Last, First409..	4090541009	Other	Processed ..	Contractual O..	Additional Do..	16 - Claim/service la..	Emergency Depart..	HC-99283 - E..	SELECT HEALTH ..	N253 - Missin..	9/30/2020	$245.00	$0.00
9/20/2020	Last, First8577 441009 D	8577441009	Regan Hospital	Denied	Contractual Obligations	Additional Documentation Needed	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At le..	Emergency Depart..	HC-99285 - E..	DHB	MA36 - Missi..	9/30/2020	$2,907.00	$0.00
								Laboratory and Path	HC-87635 - L..	DHB	MA36 - Missi..	9/30/2020	$85.00	$0.00
									HC-87804 - I..	DHB	MA36 - Missi..	9/30/2020	$204.00	$0.00
									HC-C9803 - L..	DHB	MA36 - Missi..	9/30/2020	$40.00	$0.00
								Medication/Infusion	NU-0250 - Ph..	DHB	MA36 - Missi..	9/30/2020	$50.00	$0.00
								Radiology	HC-71045 - R..	DHB	MA36 - Missi..	9/30/2020	$257.00	$0.00
9/18/2020	Last, First0058 441009 E	0058441009	Regan Hospital	Denied	Contractual Obligations	Additional Documentation Needed	16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other	Laboratory and Path	HC-36415 - R..	DHB	MA04 - Seco..	9/30/2020	$43.00	$0.00
									HC-80048 - ..	DHB	MA04 - Seco..	9/30/2020	$276.00	$0.00
									HC-81001 - U..	DHB	MA04 - Seco..	9/30/2020	$127.00	$0.00
									HC-85025 - C..	DHB	MA04 - Seco..	9/30/2020	$149.00	$0.00
									HC-87086 - U..	DHB	MA04 - Seco..	9/30/2020	$125.00	$0.00

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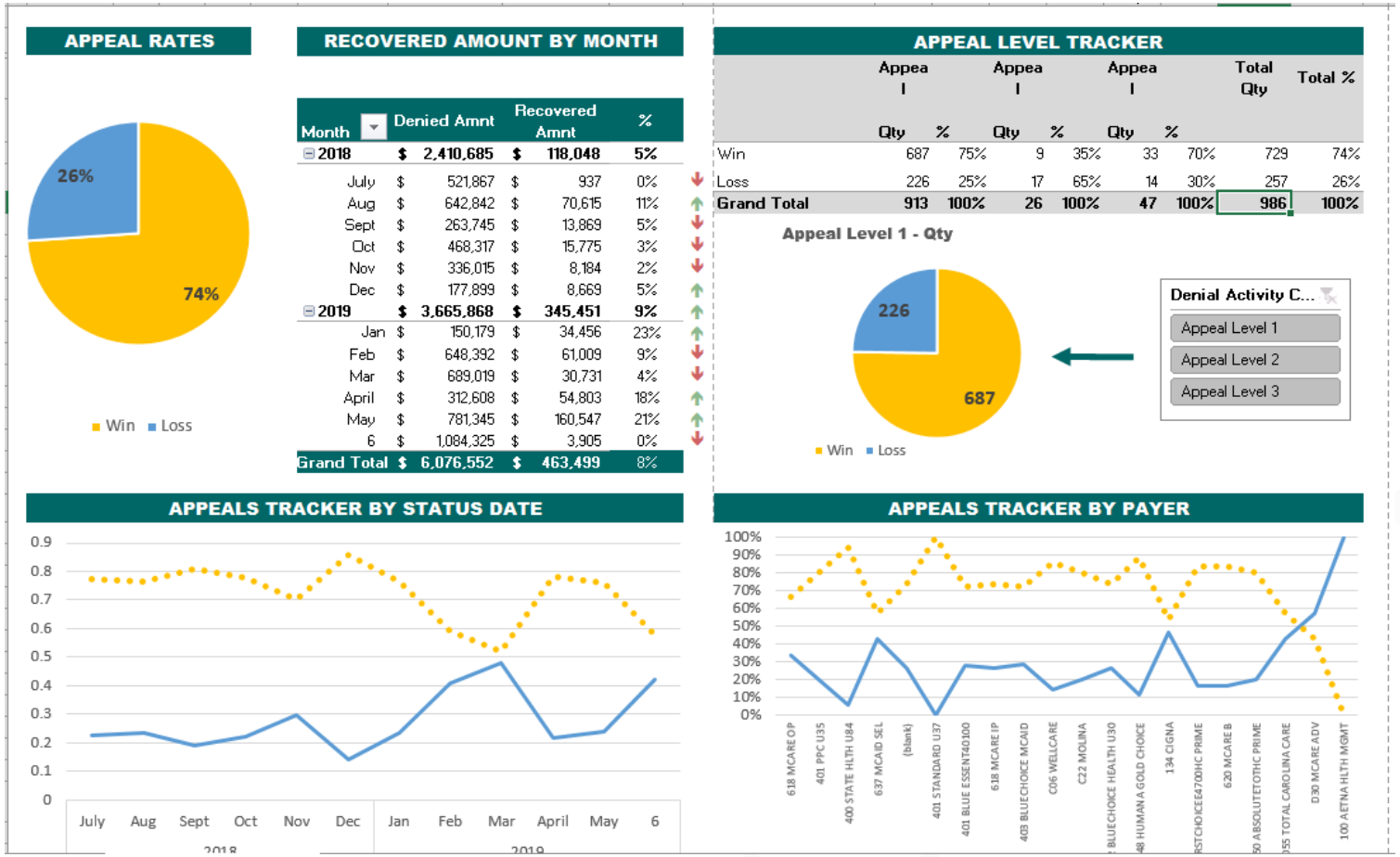
Denials Management Dashboard Sample (1/2)



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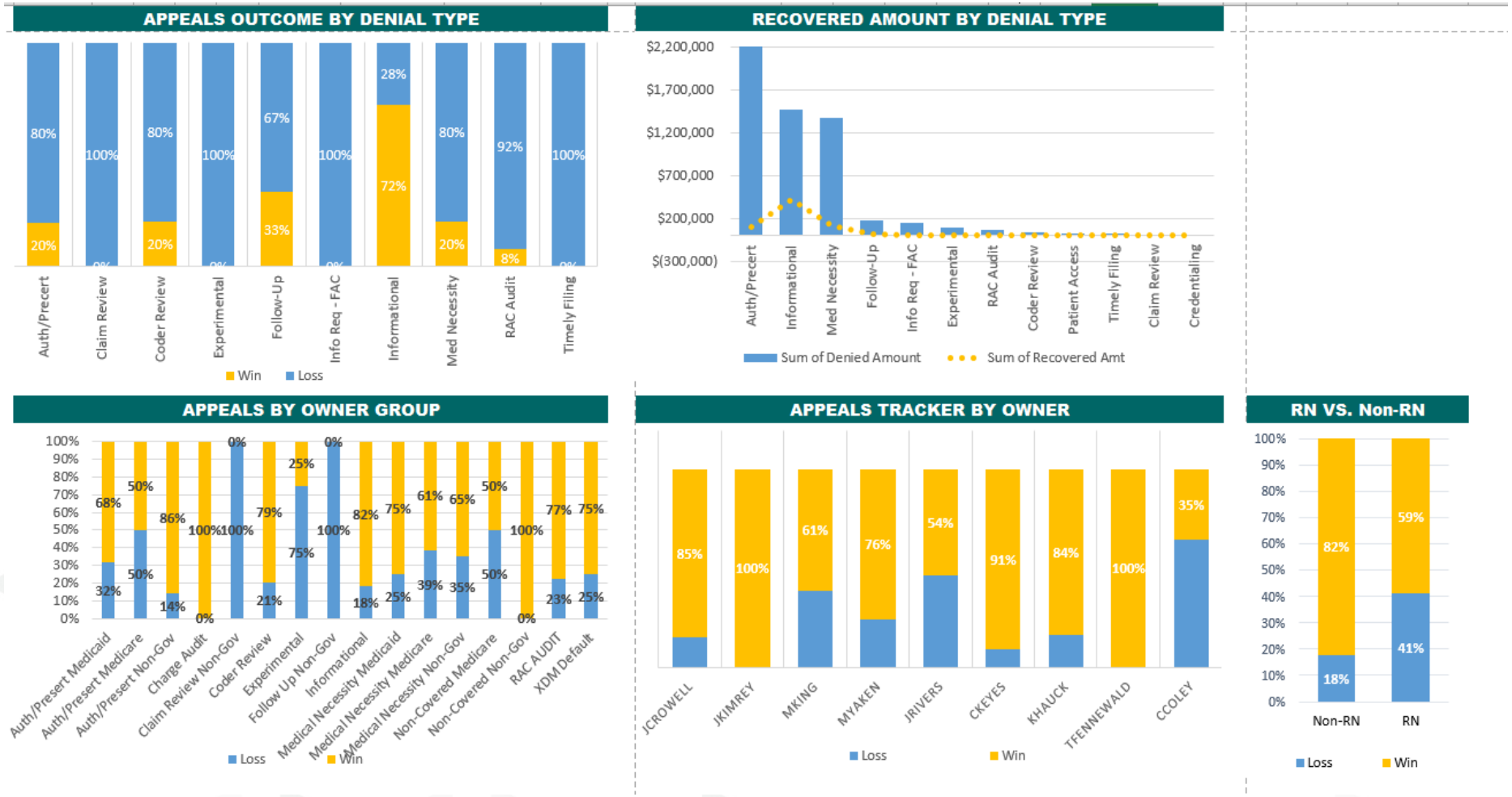
Denials Management Dashboard Sample (2/2)



Import Error Analysis Example

Sum of Total Reject Count	Column									
Row Labels	Sep-19	Aug-19	Jul-19	Jun-19	May-19	Apr-19	Mar-19	Feb-19	Jan-19	Grand Total
Data Mapping	1912	1706	1288	958	1186	1115	2148	1500	1694	13507
Provider Education	46	59	52	49	37	34	177	95	125	674
Credentialing	11	21	29	24	25	24	31	23	36	224
Eligibility	20	31	16	23	13	11	18	9	22	163
Cerner SR needed	36	36	2	5	5	13		5	27	129

Sum of Total Amount	Column Label									
Row Labels	Sep-19	Aug-19	Jul-19	Jun-19	May-19	Apr-19	Mar-19	Feb-19	Jan-19	Grand Total
Data Mapping	$ 1,582,952	$ 1,787,283	$ 1,427,019	$ 1,871,364	$ 1,952,865	$ 1,578,467	$ 5,555,519	$ 3,314,375	$ 2,119,472	$ 21,189,315
Provider Education	$ 239,671	$ 110,220	$ 78,020	$ 265,588	$ 136,265	$ 315,058	$ 375,510	$ 104,656	$ 498,783	$ 2,123,770
Mnemonic	$ 17,180	$ 16,077	$ 48,970	$ 28,986	$ 4,774	$ 8,954	$ 36,036	$ 130,279	$ 22,695	$ 313,950
Acknowledged or Crossover sent	$ 458	$ 32,353	$ 2,626	$ 23,441	$ 30,794	$ 23,371	$ 3,618	$ 398	$ 9,536	$ 126,595
Denial Response	$ 6,287	$ 11,386	$ 1,091	$ 71,356	$ 27,458	$ 531	$ 404			$ 118,513
Eligibility	$ 7,107	$ 18,800	$ 5,992	$ 18,354	$ 5,223	$ 5,303	$ 17,035	$ 1,829	$ 7,118	$ 86,762
Cerner SR needed	$ 11,315	$ 23,370	$ 353	$ 3,057	$ 10,594	$ 9,514		$ 1,234	$ 17,286	$ 76,724
Credentialing	$ 2,759	$ 5,146	$ 7,151	$ 5,185	$ 9,269	$ 8,795	$ 10,934	$ 5,388	$ 10,522	$ 65,149
Rejected - No further detail	$ 18,698	$ 2,731	$ 1,952	$ 1,219		$ 9,240	$ 4,753		$ 17,919	$ 56,511
Contract - See Prov manual for de	$ 33	$ 4,201	$ 3,531	$ 7,603	$ 4,213	$ 4,025	$ 1,182			$ 24,788

BKD

Sampling for Root Cause Issue Identification

Example: Significant timely filing denials and final write-offs at a critical access hospital

Key Findings:

- Operations
  - Low visibility on at-risk unbilled claims approaching plan-specific claim timely filing deadlines
  - High-to-low account prioritization methodology
- Technical
  - Inaccurate payer plan timely claim submission and appeal window configuration in the system
  - Zero utilization of available reporting to drive account prioritization of at-risk account
- Organization
  - Culture of accountability for DNFB reporting and resolution expectation