Revenue Cycle Management and Revenue Calculations

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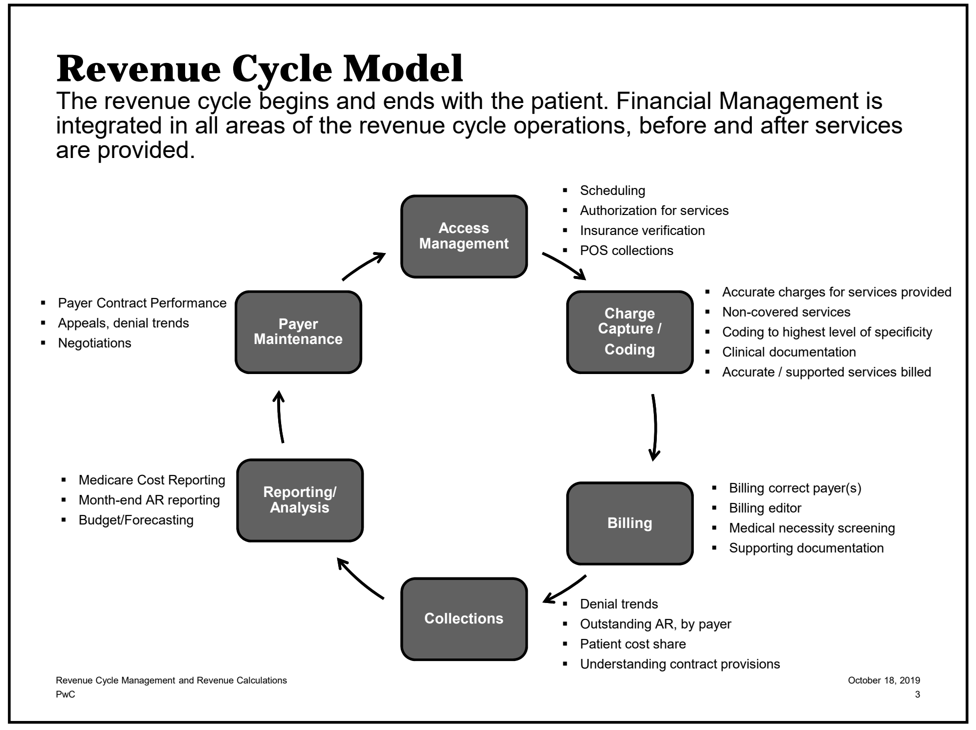

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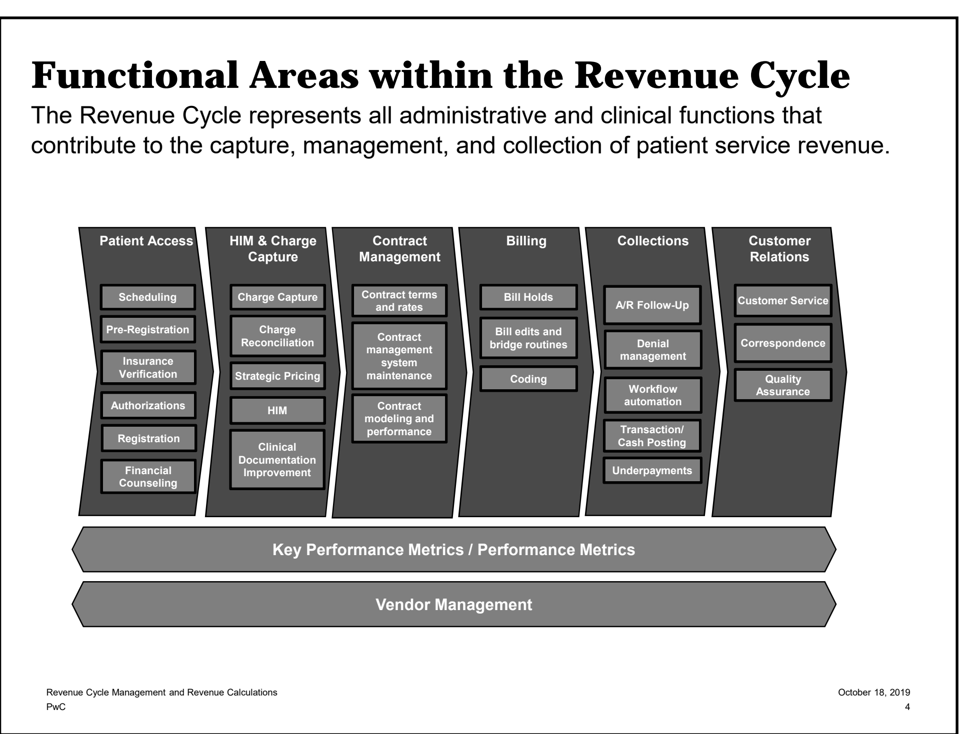

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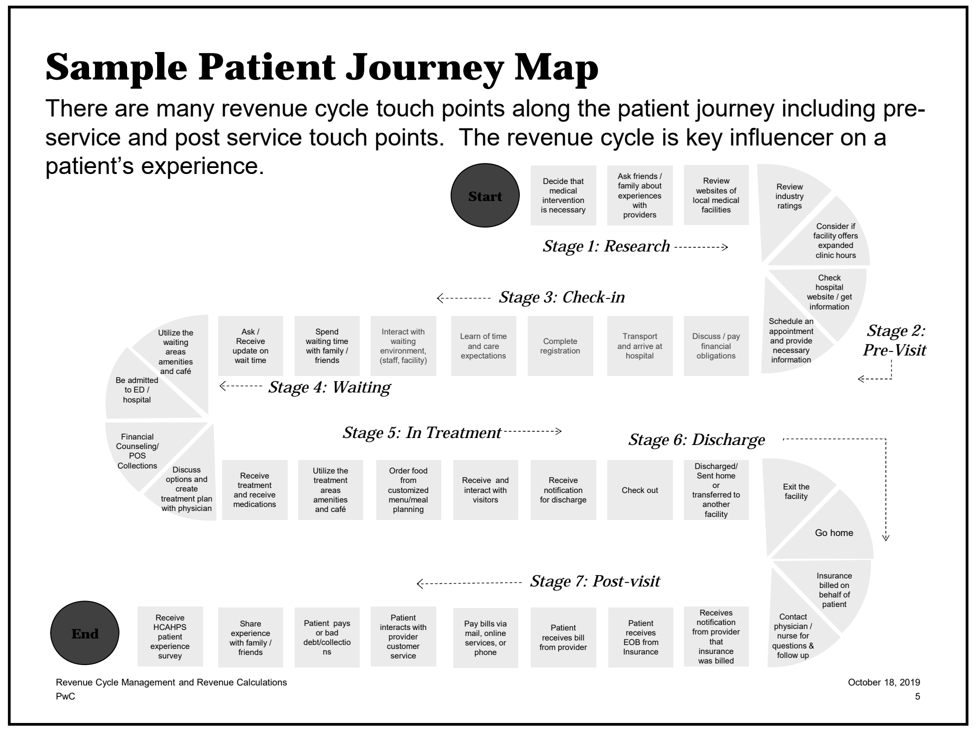

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Revenue Cycle Performance – Technical KPIs
Patient Access

The table below represents a scorecard for revenue key performance indicators (KPIs) in the evaluation of a hospital's Revenue Cycle. KPI's are compared to industry leading practice performance.

Sub-Category	Performance Metric	Description	Hospital Benchmark
Scheduling	Call Abandonment Rate	Percentage of calls that disconnected before being answered	≤2%
Scheduling	Pre Registration %	The percentage of scheduled patients pre-registered before arriving for services.	100%
Pre-registration/Pre-certification	Insurance Verification Rate	Overall insurance verification rate of scheduled/pre-registered patients	≥98%
Pre-registration/Pre-certification	POS Collections %	POS Cash Collected as % of NPSR	>2%
Financial Counseling	Financial Assistance	% of non- or under- funded patients being screened for financial assistance	≥98%

Note: Industry leading practice benchmarks are based on a combination of PwC's Revenue Cycle Consortium, HFMA, MGMA, & HARA data.

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Revenue Cycle Performance – Technical KPIs
HIM & Charge Capture

The table below represent a scorecard for revenue key performance indicators in the evaluation of a hospital's Revenue Cycle. KPI's are compared to industry leading practice performance.

Sub-Category	Performance Metric	Description	Hospital Benchmark
Health Information Management (HIM)	CDI Queries	Physician documentation completion delinquency greater than 30 days	≤5%
Health Information Management (HIM)	Chart Acquisition Lag	Average chart acquisition lag from physician request	≤90 minutes
Charge Entry	Late Charges %	Late Charges as % of Gross Revenue	≤2%
Charge Entry	Missing Charge %	Total % of total visits with missing (no) charges	≤1%

Note: Industry leading practice benchmarks are based on a combination of PwC's Revenue Cycle Consortium, HFMA, MGMA, & HARA data.

Revenue Cycle Performance – Technical KPIs
Billing

The table below represent a scorecard for revenue key performance indicators in the evaluation of a hospital's Revenue Cycle. KPI's are compared to industry leading practice performance.

Sub-Category	Performance Metric	Description	Hospital Benchmark
Billing/Claim Submission	Charge Lag Days	Charge lag days from date of service/discharge and receipt chart date	≤3 Days
Billing/Claim Submission	Days in Total Discharged Not Submitted to Payer (DNSP)	Total DNSP Gross Revenue / Average Daily Gross Revenue	≤2% A/R days
Billing/Claim Submission	Clean Claim Rate	Volume of claims requiring no manual intervention / The total volume of claims accepted into claims scrubber or clearinghouse	85%>
Billing/Claim Submission	Discharge Not Final Billed (DNFB)	Total DNFB Gross Revenue / Average Daily Gross Revenue	≤4 A/R days

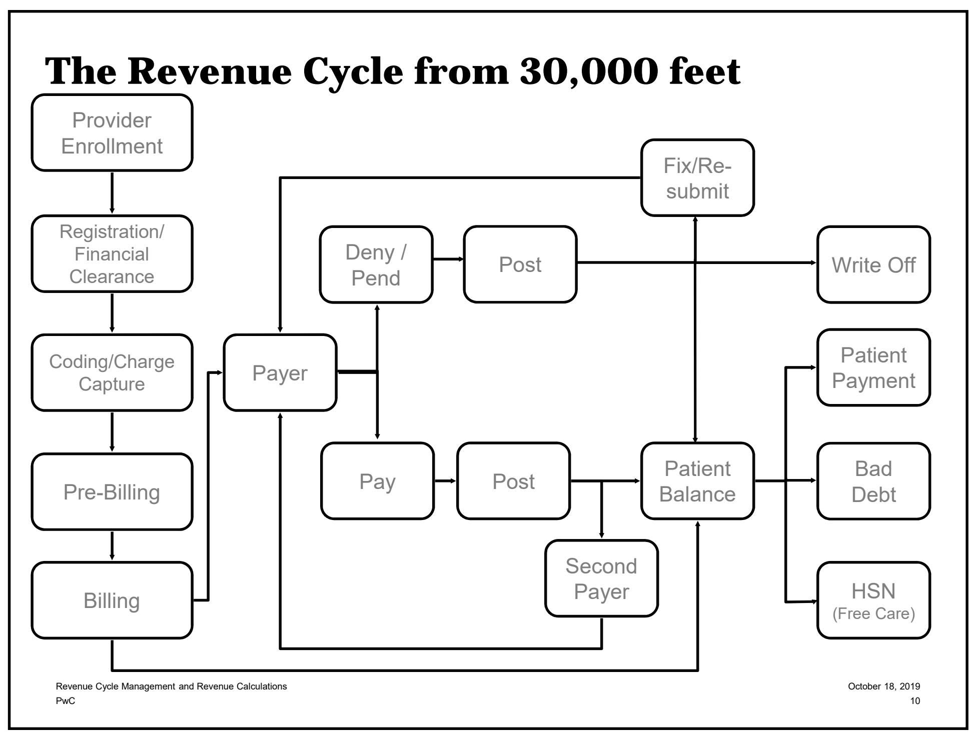
Note: Industry leading practice benchmarks are based on a combination of PwC's Revenue Cycle Consortium, HFMA, MGMA, & HARA data.

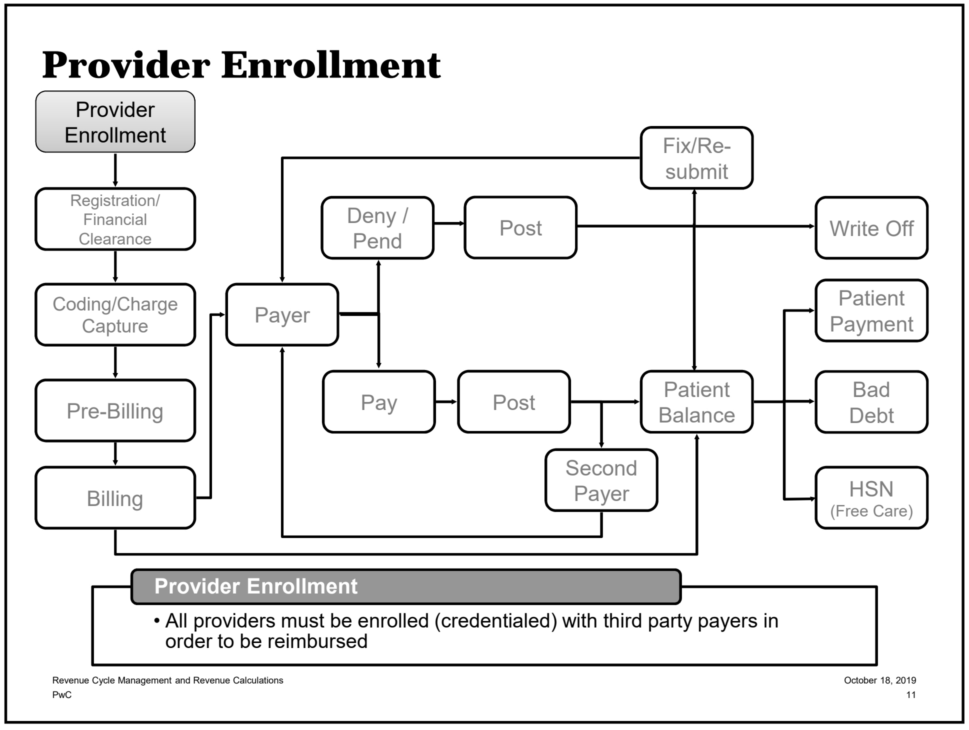
Revenue Cycle Performance – Technical KPIs
Collections

Sub-Category	Performance Metric	Description	Hospital Benchmark
Third Party	Percentage of total accounts receivable > 180 Days	Billed AR>180 days / Total Billed AR	≤5%
Third Party	Percentage of total accounts receivable > 365 Days	Billed AR>365 days / Total Billed AR	≤2%
Third Party	Percentage of total accounts receivable > 90 Days	Billed AR>90 days / Total Billed AR	≤20%
Third Party	Cash Collection %	Cash collections as % of net revenue	≥100%
Third Party	Charity Write Off %	Charity write offs as % of gross revenue	≤2%
Cashiering	Days in Credit	Average number of days the hospital takes to issue a credit on applicable accounts.	≤2 Days
Denials	Denial Overturn Rate	Percentage collected on denied accounts	>80%
Denials	Initial Denial Rate	Initial denials as a percentage of gross revenue	<5%
Denials	Initial Denial Rate—Partial Pay	Initial denials (partial payment) as a percentage of gross revenue	<5%
Denials	Net Denial Write Offs	Net denials write offs as a % of NPSR	≤1.5%
Denials	Underpayments Additional Collection Rate	The percentage of accounts where the payment received is less than the anticipated amount based on the contracted agreement.	≥12%
Collection	Bad Debt %	Bad debt as a % of gross revenue	≤2%
Management	Cost to Collect	Revenue Cycle Operational Cost / Total NPSR % collected	≤2%
Management	Gross Days in A/R	Total patient accounts receivable balance / Average daily gross patient revenue	≤50

Note: Industry leading practice benchmarks are based on a combination of PwC's Revenue Cycle Consortium, HFMA, MGMA, & HARA data.

The Revenue Cycle from 30,000 feet





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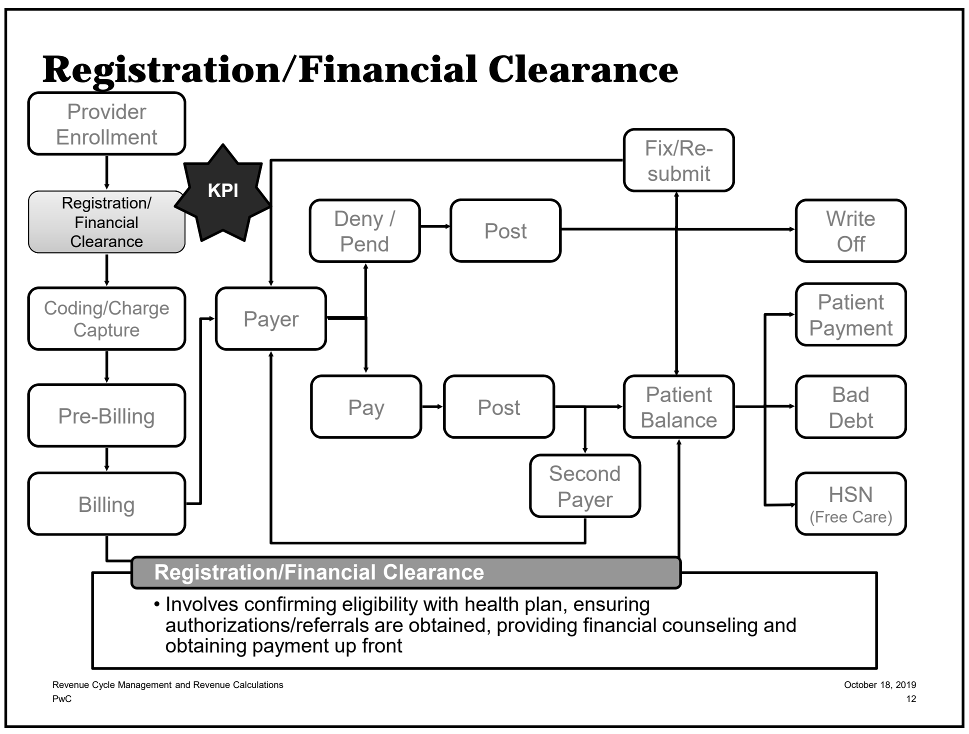

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Registration Process/Financial Clearance
High Performing Hospitals

Leading Practice: Self Check-In Kiosks; SMART Cards; Document Imagining; Wireless Bedside Registration; Electronic Signature Capture

Financial Clearance –
- Most critical set of processes in the Revenue Cycle
- If financial clearance is not done well, the likelihood of proper reimbursement decreases
- Financial Clearance consists of registration, notification, referrals and prior authorization
- Providers use real-time eligibility tools, such as NEHEN, the New England Healthcare Exchange Network
- Financial counselors access a patient's liability as well as his propensity to pay and link a patient to available funding sources

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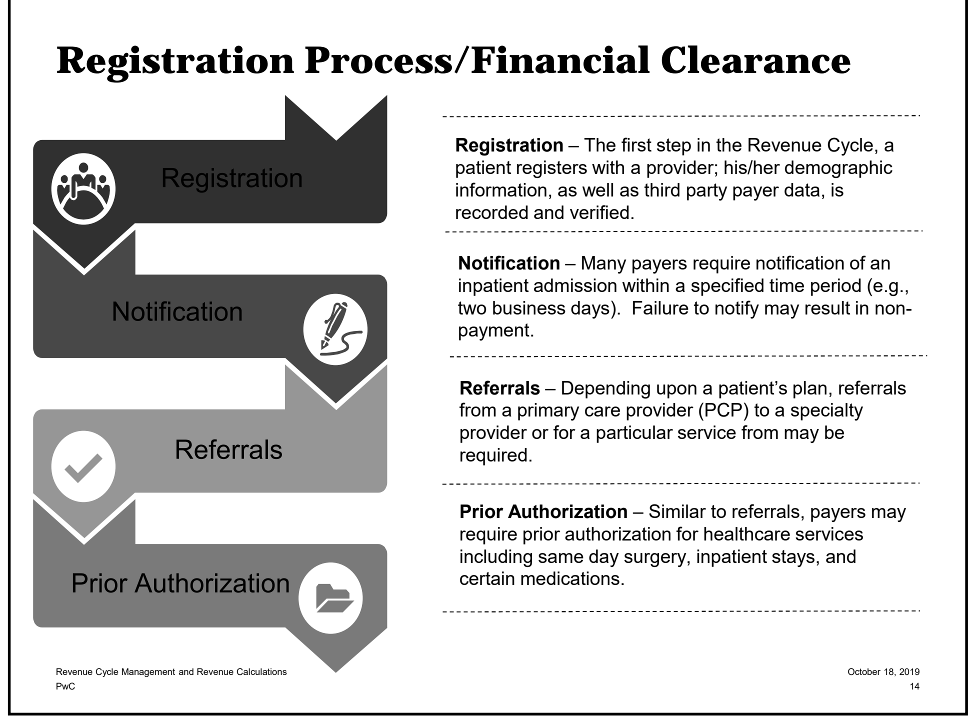

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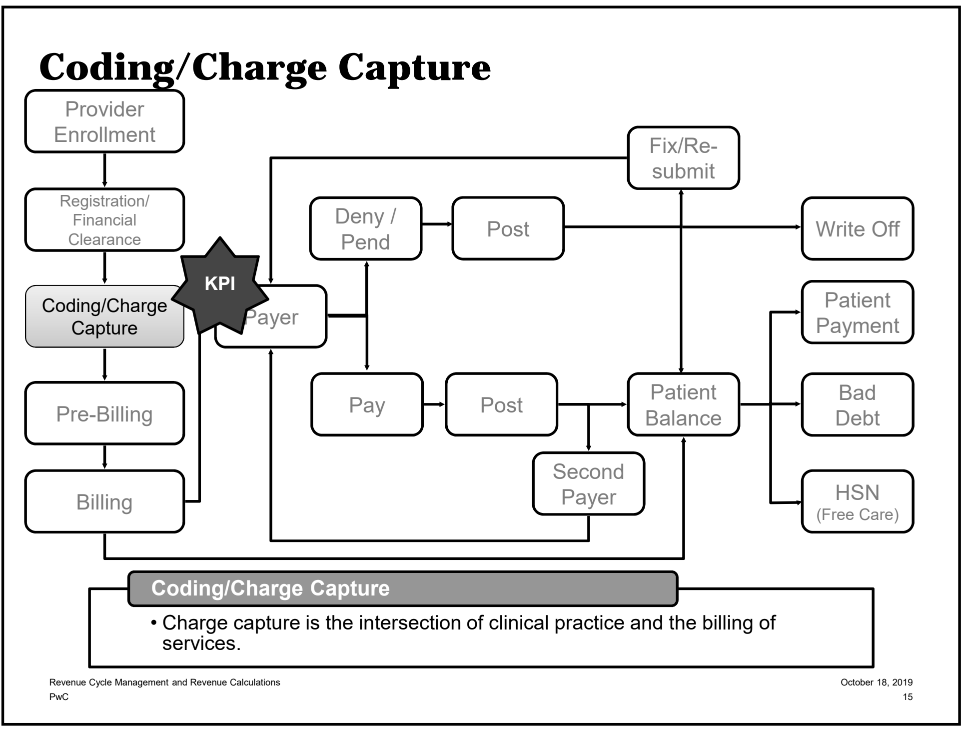

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Coding

All services are coded by a certified hospital coder

Coding for Inpatient Admissions

- Each admission is assigned a DRG (Diagnosis Related Grouper) based upon the following:
  - Admitting diagnosis
  - Principal diagnosis
  - Secondary diagnosis(es)
  - Comorbidities
  - Complication(s)
  - Principal procedure
  - Secondary procedure(s)

Coding for Outpatient Services

- Each visit has associated CPT/HCPCS codes, as well as diagnosis codes

If a procedure/service is not documented, **IT DID NOT HAPPEN**!

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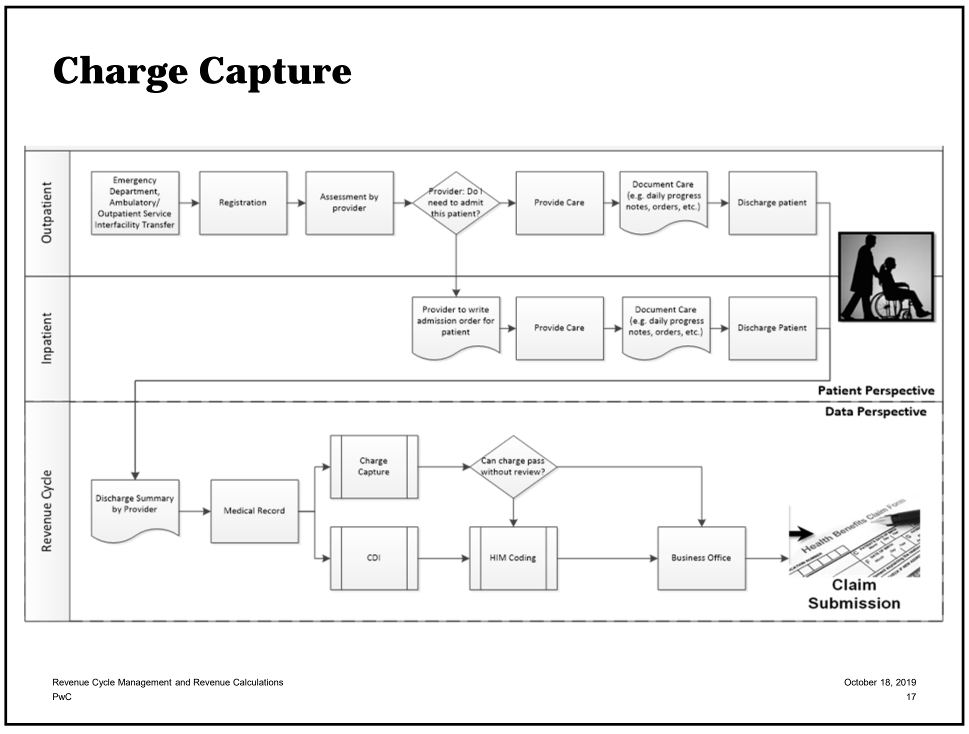
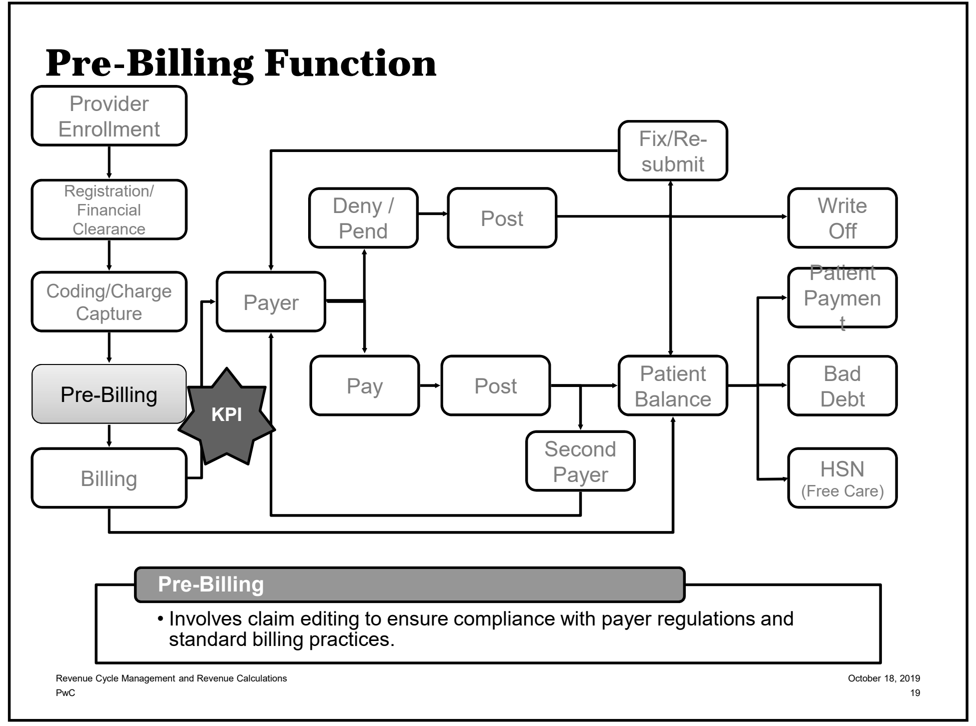
Charge Capture



Charge Capture
Documentation and Coding

- Clinical documentation has a significant impact on coding and ultimately, reimbursement for services provided to the patient. Clinical documentation directly impacts the following:

  - ✓ Regulatory compliance – JCAHO, CMS, Medicare Conditions of Participation and OIG.
  - ✓ Hospital Case Mix index – Medicare Cost Report.
  - ✓ Reimbursement for services provide – coding service to the highest level of specificity.
  - ✓ A/R days – as a result of waiting for response from physician queries.
  - ✓ Research and outcomes data



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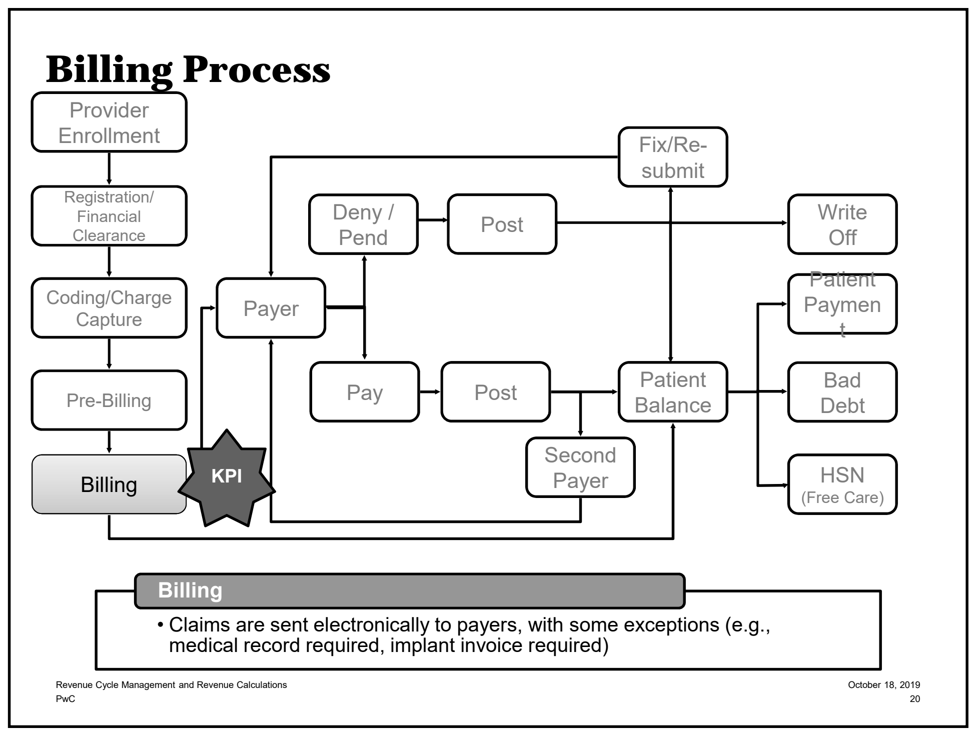

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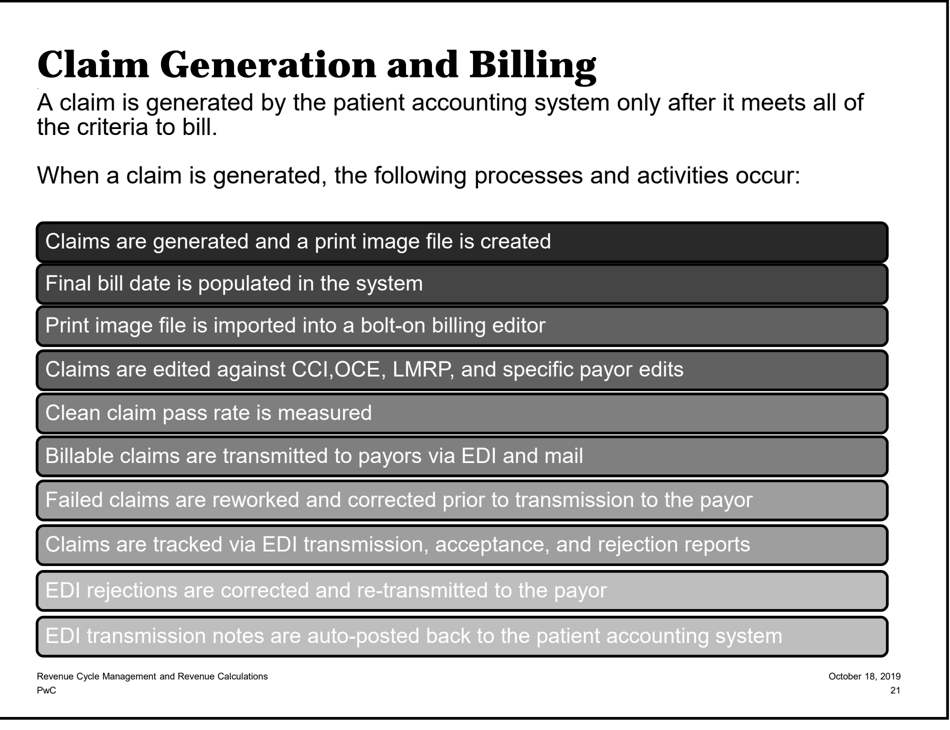

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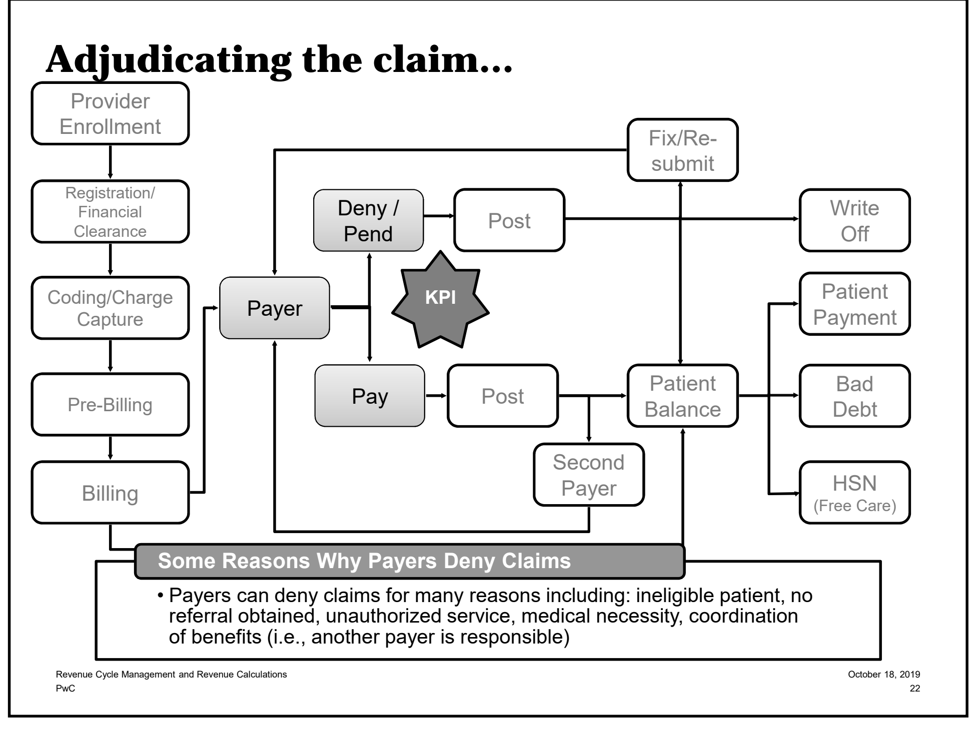

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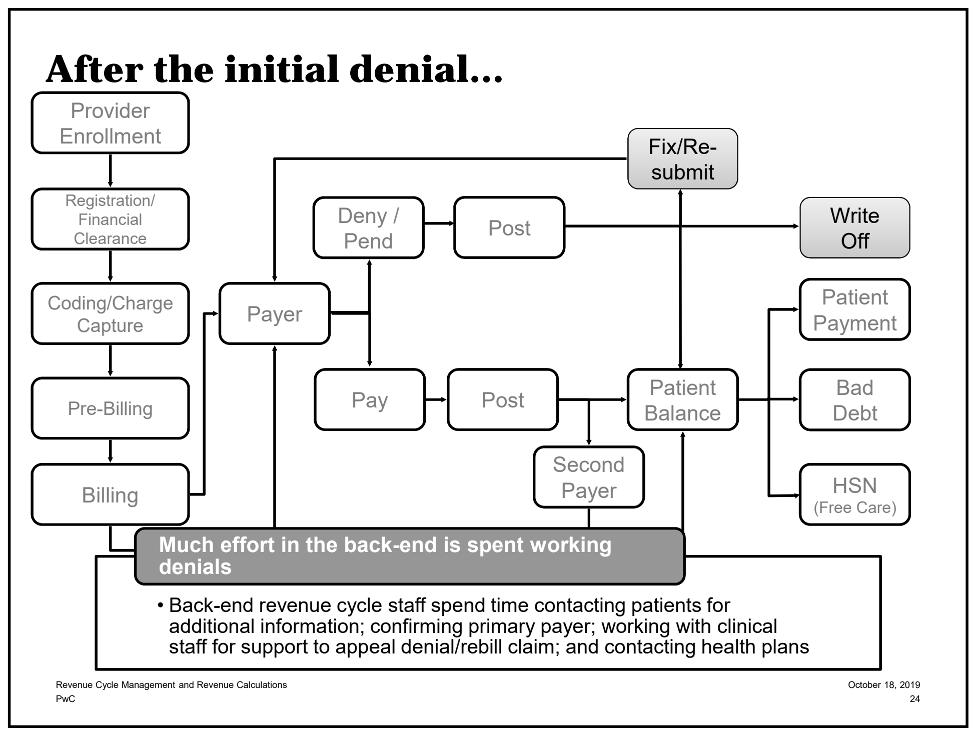
Denials and Appeals – Overview
Roles and Responsibilities

- ✓ Develop and provide oversight to the denial work group which includes key stakeholders from other departments (i.e. Access Management, Health Information Management, Case Management)
- ✓ Actively monitor denied claims through system-wide denial reporting structure and communication
- ✓ Identify and communicate trends and issues regarding clinical or administrative denials to revenue cycle leadership and/or the root cause department

Types of Payer Denials:

- **Hard Denial**: These denials occur when the payer has denied payment (either for the full claim or by line-item; i.e. Technical or Clinical Denials)
- **Soft Denial**: These denials occur when the payer will not pay a claim until the patient or hospital submits additional information to process the claim (i.e. Rejections)



Denial Management – Root Cause Analysis

Denials typically originate in the following departments:

Sample Hospital:

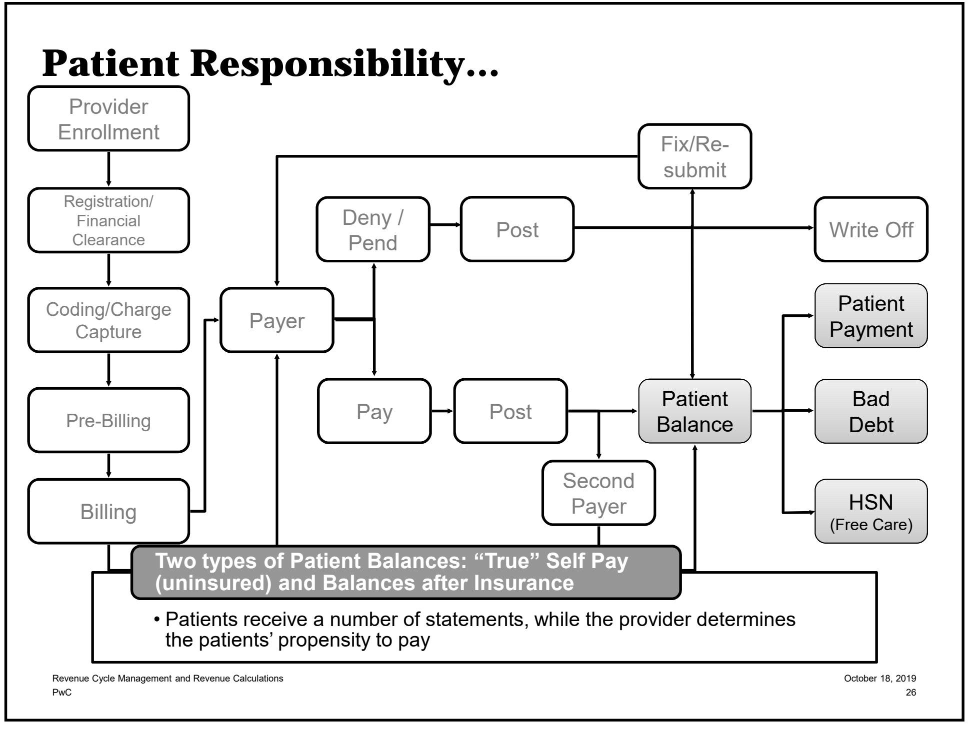
Case Management 27%
Other 2%
Business Office 41%
Patient Access 24%
Medical Records 6%

Business Office –
- Duplicate claim
- Passed timely filing deadline
- Incomplete billing attachments
- Provider name/number

Medical Records –
- Principal diagnosis/HCPCS Codes
- OCE/CCI edits

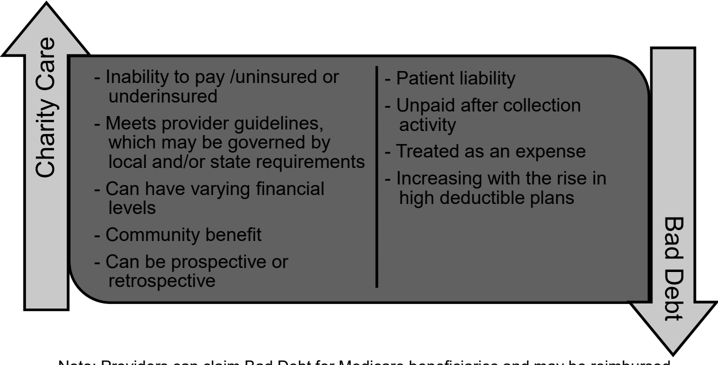
Case Management –
- Clinical / Concurrent Review
- Authorized Days
- Authorized Service
- Level of Care (Inpatient vs. Observation)

Patient Access –
- Authorization conflict
- No benefits allowed
- Other insurance is primary
- Subscriber not on file/invalid member #
- Ineligible
- Awaiting pre-authorization
- Notification not provided



Charity Care vs. Bad Debt

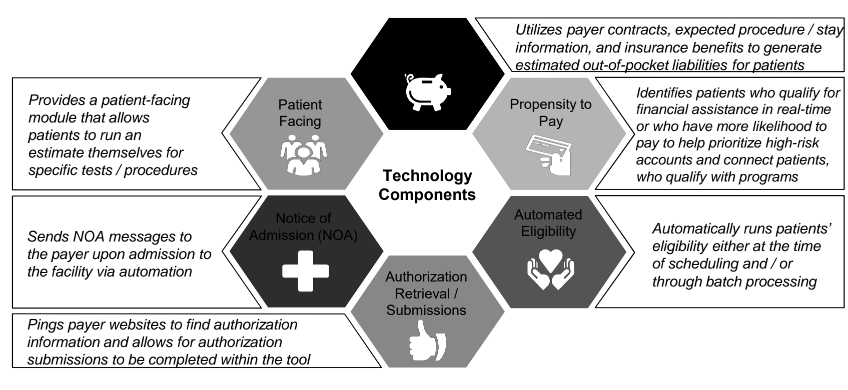
Providers often face the reality that a patient's medical bills can be the lowest priority for that patient. Depending upon the patient's financial status, the provider may treat the patient's inability or unwillingness to pay differently

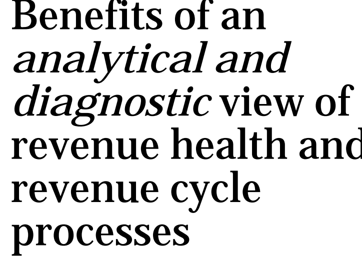


Note: Providers can claim Bad Debt for Medicare beneficiaries and may be reimbursed under the Medicare Program, when all guidelines have been appropriately conducted

Technology Advancements Across the Revenue Cycle

Several technology advancements are driving hospitals' abilities to provide patient estimates, increase patient satisfaction, and reduce bad debt





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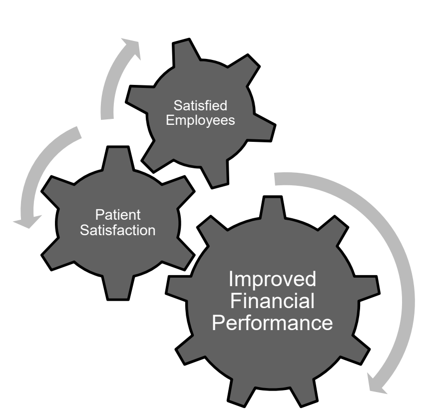
Results of an Effective Revenue Cycle

- Improved Financial Performance
  - Higher rate of clean claims that are submitted and billed
  - Improved collection efforts due to complete and accurate patient demographic and insurance information
  - Reduction in bad debt and denials
  - Reductions in variable costs
  - Increased cash flow from patient services
- Increased Patient Satisfaction
- Increased accountability with clear roles and responsibilities



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Thank you!