# REVENUE CYCLE FOUNDATIONS 103

FOR DC MEDICAID BEHAVIORAL HEALTH PROVIDERS


# Disclaimer:

The Rev Up DC Revenue Cycle Management for Practice Transformation Program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,764,326.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government

# AGENDA

1. Overview Rev UP DC
2. Accounts Receivables
3. Reconciliation
4. Recap

# WHY FOCUS ON **REVENUE CYCLE MANAGEMENT?**

**Integrated Care DC** is responding to providers' request to support and help with the transition to managed care

**Managed Care** participation will require providers' operations to be more efficient in managing payment requirements and account receivable processes

**Revenue Cycle Management** includes activities that are structured to identify, collect and manage revenue from payers for services rendered by a practice

# OVERVIEW
# REV-UP DC TRAINING

**Integrated Care DC's** new program to support DC Medicaid Behavior Health providers entry into Managed Care

**Participating Providers** will focus on Revenue Cycle Management to successfully guide their Practices' transformation into Managed Care

**Rev-Up DC** will provide revenue cycle technical support and training thru individualized assistance, customized to providers' specific needs

# HOW REV-UP DC WORKS

Revenue Cycle Management for Practice Transformation allows providers and their teams to participate in three (3) ways:


A comprehensive **Revenue Cycle assessment**, geared towards answering questions and meeting your needs

**One-on-One** individualized **Technical Assistance** sessions with one of our coaches about your practice

**Focused Revenue Cycle** Training Classes, launching with The Foundations of Revenue Cycle class series

# FOCUSED **REVENUE CYCLE** TRAINING

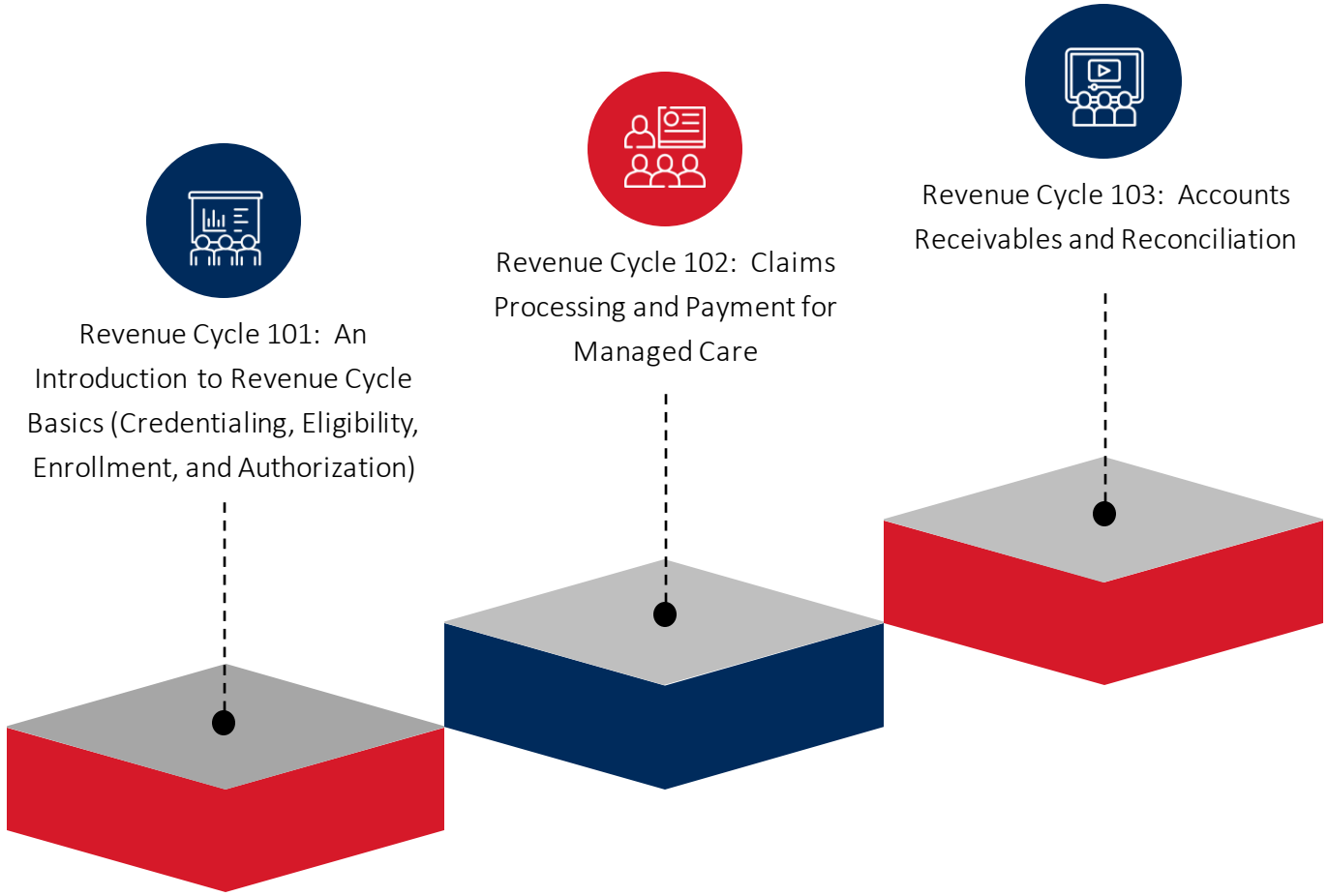
Common Revenue Cycle Management themes that are identified throughout our engagement with providers will be used to develop content to share via:

# FOUNDATIONS OF **REVENUE CYCLE** COURSE(S)

## Foundation Level Courses

Accessible to Anyone

Three (3), 60-minute, virtual training sessions created to provide basic skills and knowledge needed to be successful in a Managed Care setting with Billing, Payments, Accounts Receivables and Reconciliation.
Sessions will include:



# Pre - Assessment:

1.) What is the primary reason to establish a reconciliation process within your practice?

a.) Verify the number of doctors in your practice
b.) to measure Provider performance
c.) To verify proper reimbursement based on contract.

2.) When does the aging of a claim begin?

d.) from the date of service
e.) after 30 days of service
f.) once the claim is submitted

3.) Reimbursement of services rendered are received on:

g.) 835
h.) Payment file
i.) ERA (Electronic Remittance Advice)
j.) All of the above

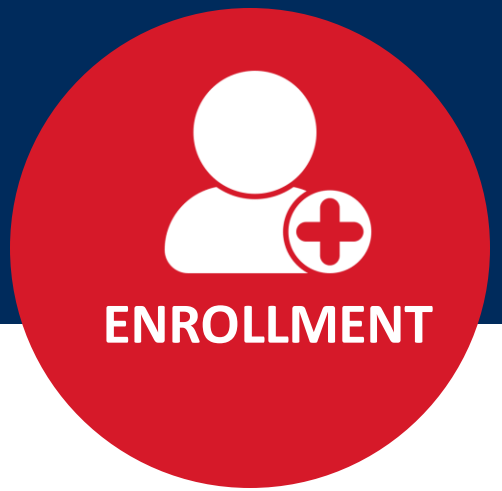
# LEARNING OBJECTIVES Foundations 103

1. Participants will determine strategies to enhance their practice's Accounts Receivables capabilities.
2. Participants will identify critical steps in the Accounts Receivables process to reduce "days outstanding".
3. Participants will be able to define action steps for their practice to most effectively manage Reconciliation of claims.

# REVENUE CYCLE OVERVIEW

Revenue Cycle Management consists of processes that support payment capabilities, focused on:










# WORKFLOW
# REVENUE CYCLE


Revenue Cycle Management for Practice Transformation
REV UP
DC

# ACCOUNTS RECEIVABLES & RECONCILIATION

# REVENUE CYCLE MANAGEMENT


## ACCOUNTS RECEIVABLES & RECONCILIATION

Practice Management System(s)

Daily Reporting
- Reconciliation of daily activity
- All services are captured and billed properly

Monthly Reporting
- Profitability of the practice
- Payer performance
- Medicaid
- Commercial
- Pay for Performance status (P4P)
- Capitation
- Aged Receivables (AR)
- Bad debt ratios
- Others

Productivity by provider

- Identify non-compliant patients (HEDIS, EPSDT, Annual screenings) and test
- Key Performance Indicators (KPIs)

Appeals, if applicable

# ACCOUNTS RECEIVABLES & RECONCILIATION WORKFLOW


## ACCOUNTS RECEIVABLES & RECONCILIATION STEPS

Once claims are submitted (electronic or manual), the aging process for receivables begins.
(0-30 days) – (31-60 days) – (61-90 days) – (Over 90 days) – (Over 120 days) – (Over 180 days)

**Claims follow up** – All submissions over 30 days without payment must be followed up per payer (MCOs) as part of A/R management.

**Payment posting** – When you receive 835 (Electronic Remittance Advice), payments are posted automatically, and errors are worked manually. Some balances will be written off or adjusted per bill line/procedure depending on contractual adjustments, zero pay procedure(s), patient responsibility if applicable and other reasons.

**Denial Review** – All denied bill lines are reviewed depending on denial reason. Some denials can be appealed. For example, if denied for lack of authorization and an authorization was obtained prior, timely filing if there's proof to the contrary. Appeal(s) must be initiated within 60 days of denial date. Unappealable denials include lack of eligibility on date of service, non-covered benefit, exhausted benefit etc.

# ACCOUNTS RECEIVABLES & RECONCILIATION WORKFLOW – CONT'D.


## ACCOUNTS RECEIVABLES & RECONCILIATION STEPS

**Appeals/ Re Bill** – must be initiated as soon as possible. This requires resubmission of all affected claims/bill lines. As discussed earlier in Foundations 102, the MCO may initiate a reconsideration if there was underpayment or denial due to an internal error.

**Write Offs** – Decisions are made by Revenue Cycle Manager depending on age of AR to write off some bad debts or decision made that charges can't be recovered due to fatal denial reasons like lack of eligibility, Non Covered Benefits etc.

**Audit** – a sample of submissions, payment posting reports etc., should be audited on a monthly basis by AR Manager or Director or Compliance to monitor performance of the Revenue Cycle Team. Results should be published.

# ACCOUNTS RECEIVABLES & RECONCILIATION PERFORMANCE MANAGEMENT


## KEY PERFORMANCE INDICATORS (KPIs)

**Key Performance Indicators (KPIs) are predetermined quantifiable measurements that reflect critical success factors for your practices. RC Industry Best Practice recommends that you measure monthly and use to track performances.**

- Days in Accounts Receivable (AR)
- Net Collection Rate
- % of AR greater than 90 days
- % of AR greater than 120 days
- Denial Rate
- Credit Balance % of AR
- Time of Service Collection %
- Charge Lag

Other useful indicators:

- % of claims billed electronically
- Payment Posting lag
- % of write off for eligibility
- % of write off for timely filing
- % of write off for authorizations

REV UP DC Coaches can assist in implementing based on RC Industry Best Practices.

# ACCOUNTS RECEIVABLES & RECONCILIATION

# 835 REPORT EXAMPLE

## Sample: 835-PLB CS Adjustment Report (Claim Level)

ED835R01 [redacted] 07/15/2010 Page : 1 of 1

835/PLB CS Adjustment Report

Transaction Receiver: 561561561

BATCH Level Information:

| Payee ID | Check/EFT Number | Check/EFT Date | Total Check Amount | Good Claims Count | Good Claims Dollars | Bad Claims Count | Bad Claims Dollars | Total Batch Count |
|---|---|---|---|---|---|---|---|---|
| **Batch** | | | | | | | | |
| 6786786783 | 1002051930001069 | 07/03/2010 | $77,210.55 | 1194 | $76,625.00 | 5 | $575.55 | 1199 |

| Patient ID / Claim ID | Patient Acct # / Service Start | Patient Last Name/ Service End | Patient First Name/ Charged Amount | Paid Amount |
|---|---|---|---|---|
| **Claim(s)** | | | | |
| YPP11122233301<br>0105011005501 | 235A45666<br>07/01/2010 | DOUGH<br>07/01/2010 | JOHN<br>500.55 | 300.55 |
| YPZ11122333301<br>0105131005501 | 235A45J678<br>07/01/2010 | LADY<br>07/01/2010 | LOVELY<br>100.00 | 50.00 |
| ZCS11123456701<br>0105141005501 | 235A451178<br>07/01/2010 | CHEEK<br>07/01/2010 | ROSIE<br>75.00 | 25.00 |
| YPH11223333301<br>0105011005601 | AAA7878<br>07/01/2010 | MOUSER<br>07/01/2010 | MICKEY<br>400.00 | 300.00 |
| YPY11122342451<br>0105011005701 | ZZZ235<br>07/01/2010 | SMITH<br>07/01/2010 | JOHN<br>-250.00 | -100.00 |

For additional information regarding these claims, please refer to the Explanation of Payment

This report is generated to assist in balancing provider accounts and should be used in conjunction with the HIPAA 835 Remittance.

[redacted]: - 835 Health Care Claim Payment/Advice v1

[redacted]. Unauthorized copying or use of this document is prohibited.

# ACCOUNTS RECEIVABLES & RECONCILIATION

# AGING REPORT EXAMPLE

## Insurance Aging Report

| | $ 540,384.00 | $ 396,673.00 | $ 82,604.00 | $ 34,231.00 | $ 15,890.00 | $ 540.00 | $ 10,446.00 |
|---|---|---|---|---|---|---|---|
| **Carrier** | | **Current** | **Over 30** | **Over 60** | **Over 90** | **Over 120** | **Pending/Review** |
| Managed Care Organization A | | $ 31,215.00 | $ 11,230.00 | $ 415.00 | $ 95.00 | $ 115.00 | $ 2,352.00 |
| Managed Care Organization B | | $ 85,369.00 | $ 65,215.00 | $ 33,521.00 | $ 12,541.00 | $ 425.00 | $ 6,584.00 |
| Managed Care Organization C | | $ 129,852.00 | $ 4,589.00 | $ 233.00 | $ - | $ - | $ 658.00 |
| Managed Care Organization D | | $ 95,125.00 | $ 1,254.00 | $ - | $ 3,254.00 | $ - | $ - |
| Managed Care Organization E | | $ 55,112.00 | $ 316.00 | $ 62.00 | $ - | $ - | $ 852.00 |

| Encounter ID | Patient ID | Patient Name | MCO | Current | Over 30 | Over 60 | Over 90 | Over 120 | Pending/Review |
|---|---|---|---|---|---|---|---|---|---|
| 20210715G0021 | A17254 | Allen Thompson | A | $ 345.00 | $ 4,215.00 | | | | |
| 20210713G0016 | 98764R23 | Paul Sims | A | | $ 3,315.00 | | | | |
| 20210617G0016 | A32140 | Carrie Smith | C | $ 2,112.00 | $ 305.00 | | | | $ 658.00 |
| 20210817G0017 | A23984 | Richard Price | C | $ 987.00 | $ 1,262.00 | | | | |
| 20210917G0018 | JON43289 | Timothy Jones | C | $ 987.00 | | | | | |
| 20211017G0124 | 09876K821 | Kimberly Jenkins | B | | | | $ 3,587.00 | | |
| 20211005G0256 | 32158T326 | Maria Garcia | C | $ 875.00 | | | | | |
| 20211005G0213 | PRI125834 | Terrence Prichaard | D | | | | $ 3,254.00 | | |
| 20211005G0175 | 156KT1236 | Linda Hunt | C | | $ 315.00 | | | | |
| 20211006G0182 | 156BR9845 | Soon Yung Pak | A | | | $ 415.00 | | | |
| 20211012G0177 | 575BN3514 | Karen Simpson | C | $ 365.00 | | | | | |
| 20211016G0921 | A85214 | Gloria Sanchez | B | | $ 3,214.00 | | | | $ 2,215.00 |
| 20211005G0179 | WEL238547 | Tara Wells | D | $ 3,256.00 | $ 210.00 | | | | |
| 20211017G0220 | QUA32584 | Dexter Qualls | E | | $ 316.00 | | | | |
| 20211017G0322 | A62574 | Troy Madison | C | $ 698.00 | | | | | |
| 20211017G0412 | 35871T652 | Toni Williams | B | | | | $ 287.00 | | |
| 20211017G0023 | A32158 | Edward Offu | B | | | | $ 365.00 | | |

# ACCOUNTS RECEIVABLES & RECONCILIATION

## SCENARIO #1


A Behavioral Health Practice has 125 active patients in outpatient therapy. The practice has another 75 established patients under care. On average the practice submits 100 claims per week for reimbursement. The claims are submitted electronically, and payments are posted through EFT Electronic File Trans. A report/payment file is included with each transaction. The report includes a payment and denial indicator. The claims/Audit representative reviews this report weekly as a standard operating procedure(SOP) for claim reconsideration. The MCO also provides a paid claims report for all claims processed by the respective Vendor/Provider. This report includes the billed amount, paid amount, denial, and denial codes.

The Claims Representative receives the payment files electronically through the FSFTP site after each Check run/output from the MCO. The primary role of the representative is to review this report for proper reimbursement based on the contractual guidelines and the fee table. This process requires an expert(SME) familiar with reimbursement rates and payor guidelines.

Over the years the practice grew, so the representative developed a process to reduce the amount of time to review these reports. The representative filtered the report by paid claims by adding a formula to determine each claim was reimbursed by 30%. If so, this claim was considered paid appropriately and no further action is required. Sally the rep also decided to apply more time to the denials by focusing on the denial indicator. The representative would filter the report by "0" which indicates no payment was received. The representative would then review the denial codes for possible reconsideration or Appeal. As indicted in Foundation 102 a provider has 60 days from the date of the denial to appeal a claim. While the practice grew and the number of claims submitted increased, the reimbursement did not measure up.

# ACCOUNTS RECEIVABLES & RECONCILIATION

## SCENARIO #1 CONT'D.


The Compliance Department conducted an Audit on Accounts Receivables after the First Quarter. As a best practice, the Provider decided to work with the Claims department on a monthly basis to determine payment accuracy, trends and reconcile any outstanding A/R related issues.

What do you think the Compliance team discovered during an audit of the claims paid versus the reimbursement?

What steps should the Claims/Audit/SME have taken to determine proper reimbursement?

As a result: Compliance found that while claims were paid, they were *NOT* reimbursed at the contracted amount. In most cases claims were underpaid. All services are not reimbursed at the same rate. Therefore, the method the representative used was not valid.

The Compliance team discovered $250K in underpayments. The practice was able to recoup the underpayments within 60days. This enabled the Finance team to provide an accurate account of the Practice performance.

*Valuable Revenue Cycle tip* - establishing an appropriate reconciliation process after each payment transaction will identify these trends timely, eliminate the risk of lost revenue and ensure the practice is receiving proper reimbursement in a timely manner. This process will also provide the true performance of the practice.

# CLAIM RECONCILIATION EXAMPLE

| Claim # | Member Name | DOS | CLAIM TYPE | VENDOR NAME | NPI # | BILL AMOUNT | PAID AMOUNT | PAYMNET DATE | ADJ. | INDICATOR | CHECK # | LOB |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 98745632 | SMITH, SAM | 5/5/2021 | M | GW HEALTH SYSTEM | 9874563200 | $1,258.38 | $0.00 | 8/2/2021 | D77 | 0 | 6491 | 200 |
| 12345678 | DENA, RYAN | 7/2/2021 | M | MEDSTAR HEALTH SYSTEM | 7894560025 | $989.00 | $123.12 | 8/2/2021 | | 1 | 9871 | 200 |
| 85401269 | GROVE, DYLAN | 6/22/2021 | ER | HOWARD UNIVERSITY HOSP | 7419006325 | $1,282.28 | $625.45 | 8/2/2021 | | 1 | 96321 | 100 |
| 25836974 | SWIFT, TAMMY | 6/8/2021 | ER | HOWARD UNIVERSITY HOSP | 2500836974 | $1,485.24 | $673.25 | 8/2/2021 | | 1 | 96321 | 200 |
| 56479812 | GREENW, TAYLOR | 7/9/2021 | ONA | PROVIDENCE HOSPITAL | 8529631200 | $867.00 | $562.12 | 8/20/2021 | | 1 | 78945 | 200 |

UNDERPAYMENT

8%

PAYMENT INDICATOR

# CONCLUSION
# REVENUE CYCLE MANAGEMENT


## REVENUE CYCLE FOUNDATIONS RECAP

- **Registration** – validating demographics with current address, phone number, current address and insurance
- **Eligibility** – verify active coverage for all dates of service (2 months)
- **Authorization** – obtain authorization for ordered services with supporting documentation
- **Credentialing** – confidential formal review of provider qualifications when applying for
- **Claim submission** – include member demographics, provider ID/Vendor name, address, NPI#, Tax ID#, billable ICD – 10,CPT codes and authorizations, diagnosis codes and Provider signature
- **Denial Management** – Review of suspended or pended claims for reconsideration or appeal
- **A/R Follow-up** – review of payment files(835) for errors, payment discrepancies and underpayments
- **Reimbursement/Reconciliation** – review of posted payments, adjustments applied reconciliation and check dates for Provider performance

# CONCLUSION
# REVENUE CYCLE MANAGEMENT


# PUTTING IT ALL TOGETHER

# Post - Assessment:

1.) What is the primary reason to establish a reconciliation process within your practice?

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# QUESTIONS?

Thank you for attending the Revenue Cycle Foundations 103 education session. Please complete the Revenue Cycle Foundations 103 Satisfaction Survey, which will be sent to you via email. Once you have completed the Satisfaction Survey, you will receive:

1. The Revenue Cycle Quick Reference Guide
2. The Revenue Cycle Foundations 103 presentation slides
3. The Revenue Cycle Foundations 103 session recording

Sign up for Rev Up DC by registering at:
Rev-Up DC: Behavioral Health Provider Survey

Questions? Contact us at RevUpDC@integratedcaredc.org

More information on Integrated Care DC is available at:
https://www.integratedcaredc.com/