Revenue Cycle Best Practices

(Each hour on the front end of the Revenue Cycle Process saves five hours on the back end)

Provider Enrollment:

- Are all providers (including Non-Physician Practitioners) credentialed with the billing TYPE II NPI?
- Are all providers enrolled/credentialed with all insurers?
- Are all NPP's enrolled/credentialed with all insurers that will allow?
- Are all providers enrolled/credentialed to all locations where services are performed?
- Is there malpractice coverage for all locations where services are performed for all providers (some states require state specific insurers)?
- Are there written billing policies concerning billing insurers for NPP's when those insurers do not credential NPP's?
- Do you have a copy of fee schedule by insurer for all insurers?

Registration:

- Is all demographic information obtained when a new patient calls for an appointment (name, address, phone, insurance information, secondary liability – i.e. auto accident, WC claim, emergency contact, etc.)
- Is financial policy FULLY explained to new patient at scheduling and signed by patient and placed in patient file?
- Is patient insurance and eligibility verified electronically at scheduling, determining eligibility, copay and deductible amounts?
- Is that information entered into the practice management system?
- Is patient re-contacted if eligibility fails to obtain correct information prior to visit?
- Is the written Financial Policy provided to the patient ahead of time? Is it available on your website?
- Is patient eligibility re-verified 24 hours prior to physical appointment?
- Are practice forms available online for completion prior to visit including demographic information, past medical history, Medicare secondary payor questionnaire (if appropriate) and Financial Policy?
- Do you require a credit or debit card to be kept on file for each patient?
- Do you obtain authorization to bill credit card for account balances and is this authorization form on file?
- Are you compliant with PCI requirements and with maintaining patient credit/debit card information in your merchant services system, not on paper?

Check-in/Check-Out:

- Is patient information verified with the patient at check-in, including photo ID, verification of or copying and scanning of insurance cards at every visit?
- Is patient copay collected prior to seeing the provider – at check-in? At check-out?
- What is the process if patients do not pay at the time of service?
- Are patients reminded of outstanding balances during the appointment reminder process and at check-in and ensure a payment is received prior to seeing a provider?

Documentation:

- Are there standards for providers to complete documentation of the patient encounter within specified periods of time?
  - Office services – 24 hours,
  - Nursing Home – 48 hours,
  - Hospital - 48 hours
  - Other OP facilities – 48 hours.
- Are standards enforced (penalties for not completing documentation?)

Coding:

- How is coding for level of care for office E/M services and procedures determined?
  - Provider at the time service is rendered.
  - Coder from documentation?
  - PM System automatically assigns?
- How are services performed outside the office coded (level of care, procedures)
  - Provider at the time service is rendered.
  - Coder from documentation?
- If coder,
  - Are all coders certified (AAPC [CPC}, AHIMA [CCS-P])
  - Are there standards for coding?
    - Office Services within 24 hours?
    - Non-office services with 48 hours of receipt?
  - Is coder compliance with standards part of their performance evaluation?
- If provider:
  - Have documentation tools been developed to assist providers in the documentation process?
  - Is there in-house resource for providers to query if they have questions?
  - Are there individualized educational sessions by provider, based upon the results of their regularly scheduled documentation compliance audit?
  - Is a "claim hold" placed on any provider not meeting practice accuracy rates?
- Are there regularly scheduled coding education sessions for providers and coders to address new insurer policies, bundling, changes in documentation, new codes for reporting, etc.?
  - Are they mandatory?
  - Is this process part of your overall compliance plan?
  - Is participation in mandatory sessions part of performance evaluations for coders and providers?

Charge Entry:

- Are there standards for providers to turn in non-office charges (inpatient hospital, nursing home visits, ASC services, OP-hospital charges, etc.)?
  - Standards should be within 24 hours of the service.
- Are there penalties for non-compliance with the standard, including definition of extenuating circumstances?
  - Provider Fines?
  - Withholding of compensation based upon delinquent charge submission?
- Processes for capturing all charges
  - Missing charge report from practice management system - daily
  - Hospital and Nursing Home census by day – monthly
  - Surgery/Procedure schedules for hospital or ASC by day – monthly
- Process for ensuring accurate charge entry.
  - Services requiring modifiers (NCCI edit compliance)
  - Bundled Services (NCCI edit compliance)
  - Diagnosis specificity
  - Medical Necessity (Correlation between service and diagnosis)
  - Global Period compliance

Claims:

- What percentage of primary claims are filed electronically? Paper?
  - Tracked by insurer?
- Are system claim edits (set up for modifiers, global periods, bundling) worked daily to be corrected and filed?
- Are clearinghouse rejections worked daily, corrected and refiled?
- Are claims filed daily? (Primary and Secondary for those that do not roll over automatically)
- Do you know what percentage of your claims are rejected by the insurer for the following reasons?

  - Duplicate Claim (common practice – instead of working each claim, simply refile outstanding claims)
  - Past Filing Limits
  - No prior authorization
  - No referral
  - Patient not covered on date of service (coverage terminated)
  - Incorrect Patient/Subscriber Identifier (patient not recognized)
  - Medical necessity (diagnosis/service correlation)
  - Service included in primary procedure (bundling)
- What is the process for working claim denials?
- Do you know the most frequent denials by insurer?
- Do you know how quickly your rejected claims are worked to be corrected and refiled?
- Do you know the total percentage of denied claims?
- Is your practice management system set up to track specific claim denial reasons (listed above)?
- Do you track denial metrics to ensure your billing staff are learning and lowering the denial rate?

Payments:

- Percentage of electronic remittances among payors
- Post electronic remits daily
- Coordinate with bank deposits
- Separate individuals taking in office payments and preparing deposits
- Do you have daily reconciliation requirements against daily schedule, all payments received or not received and does this match each daily deposit and kept on record?
- Have CPA verify (spot check) deposits as compared to summary from PM system (totals of cash and checks). Checks and balances
- Use bank lockbox for mail payments

A/R Management (Including KPI's)

- Days in A/R (less than 30 is optimum)
- Do you know the benchmarks for your specialty on what you're A/R buckets should be/
- Contractual vs Cognitive write-off's.
  - Are they separated in the PM system?
  - Who has authority to write off a balance that is not contractual?
- Tracking W/O percentage over time and investigating anomalies or increases
- Age of patient A/R
- Aged accounts receivable (positive balances)
  - Analysis by insurer, by CPT code, by provider to determine issue
- Aged accounts receivable (credit balances)
  - Do you regularly run credit balance reports and return monies to patients in accordance with state law?
- Review Gross and Net Collection percentages
  - Gross collection % is a function of fees compared to collections and can vary greatly
  - Net collection % is a reflection of the amount collected of what the practice should receive after contractual adjustments (should be in the 98-100% range)
- Set up specific adjustment codes (i.e. contractual, denied-late filing, denied-wrong insurance, denied-not covered on DOS, etc.) to more easily track all adjustments
- What percentage of patients with balances get statements? (should be 100% unless insurer prohibits (Medicaid, WC).

Audit Process

- Charge capture audits
  - Date of service to documentation completion
  - Documentation to date of coding

- Coding date of service to charge entry date
- Charge entry to date of billing
  - Review EOB's for dates of service to insurer receipt of claim

- Documentation and Coding compliance audits using outside certified auditors, rather than inhouse coders for each provider.
- Organizational accuracy rate requirements?
- Provider compensation and contracting tied to documentation compliance and accuracy rates for coding and overall Revenue Cycle performance?

Patient Credit Balances

- Credit balance reports should be reviewed monthly
- Credits should be discussed with patients on whether to apply to next visit or refund
- Any credits you are unable to refund to patients should be turned over to State Unclaimed Property department

Compliance

- Does your practice have a compliance plan?
- If yes, is the plan compliant with OIG guidelines and requirements?
- Do all staff know the details of the compliance plan vs "on the shelf and no one looks at it".
- Are all of your staff educated and trained annually on all areas of compliance as required by law (HIIPAA, OSHA< CMS, OIG, FWA, etc)
- Are any services billed "Incident To"
  - Is there a provider on site when these services are rendered?
  - Do the services billed "Incident To" meet the regulatory definition of "Incident To" services?
  - Do the services provided fall within the "scope of practice" of the staff member who is rendering the service?
- Compliance with Insurer, Federal and State refund and escheatment regulations?

Policies and Procedures:

- Are there policies and procedures to address all the above.
- Is there a process to review policies on a yearly basis or more frequently if changes occur?
- Are these meetings/reviews documented (date, time, place, attendees)?