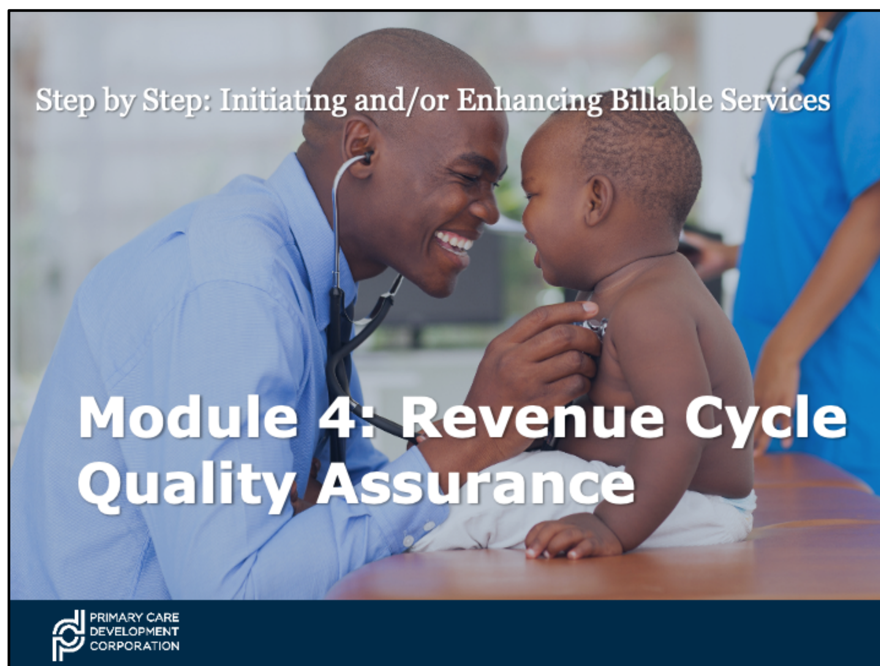

Welcome to the Step by Step: Initiating and/or Enhancing Billable Services Module 4: Revenue Cycle Quality Assurance

RR Health Strategies

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Learning Objectives

- Examine key performance indicators
- List varying financial reports for monitoring
- Discuss common billing pitfalls
- Describe the steps in billing financial reconciliation processes, re-credentialing, and bell curve monitoring

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Key Performance Indicators (KPIs)

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Effective KPIs

- A Key Performance Indicator **(KPI)** is a measurable value that demonstrates how effectively a practice/clinic is achieving key business objectives
- Selecting the right **KPIs** will depend on your practice/clinic and which parts of the revenue cycle you wish to track
- An excellent way to stay ahead is to determine the goals for the practice/clinic, and associate a **KPI** for measuring those goals
- Create a schedule to generate these reports and track the practice/clinic's progress

Healthcare KPIs are a valuable tool to assist in monitoring the operations and overall effectiveness of a practice.

Operational KPIs

- **Patient wait time:** Average amount of time a patient must wait between check-in and seeing a provider. Allows for insight to staffing and scheduling issues
- **Average number of patient rooms in use at one time:** Demonstrates how well space is used and helps determine if more or less space is needed in the practice/clinic
- **Staff-to-Patient ratio:** Indicates the use and capacity of staffing resources, which may affect the quality of patient care delivered

The evaluation of practice operations can improve the overall efficiencies of the practice/clinic.
The patient experience can also be impacted by identifying any potential issues or bottlenecks.

Financial KPIs

- **Efficiency and Utilization:** Use of resources, including provider time, space and staff
- **Physician Productivity:** Analysis of work relative value units (RVUs)
- **Revenue Cycle Optimization:** Examination of net charges to cash collections, total collections, charge posting lag, missing charge rate, claim denial rate and patient debt

- Understanding the basics of operating a practice are essential for financial success.
- Familiarize yourself with RVUs and the impact they have on the revenue cycle process.
- RVUs are import to Administration, as well as to the providers (depending upon their employment contracts).

Communications KPIs

- **Overall Patient Satisfaction:** Calculates satisfaction levels by combining several factors related to:
  - Accessibility of the practice/clinic
  - Physical appearance of the practice/clinic
  - Telephone etiquette
  - Staff evaluation including communication with the provider
  - Quality of care
  - Fees and payment procedures

- Telephone training (operation and etiquette) is essential for all staff.
- The patient’s first interaction with the practice/clinic will have a lasting impression.

Internal KPIs

- **Departmental Trainings:** Tracks the amount of trainings provided or required of the staff
- **Number of mistake events:** Measures the number of mistakes made, which indicates the effectiveness of the staff and the equipment
- **Patient confidentiality:** Measures the number of times a patient's confidential medical record was compromised or seen by an unapproved party

- Ongoing training must be part of practice operations to ensure that quality is maintained.
- This is an often overlooked area for smaller practices/clinics.

Public Health KPIs

- **Immunizations:** Demonstrates the number of patients who have received immunizations, reflecting the contribution to overall community health
- **Number of educational programs:** Indicates the time and effort in providing education to patients. Referrals to outside community education programs is fundamental

- Public health monitoring is a greater focus as “value-based” healthcare becomes an integral component of reimbursement.
- PCMH and MACRA are two programs that monitor quality measures.

Clinical KPIs

- **Medication errors:** Measures the number of times an error in prescribing medication occurs at the practice/clinic
- **Patient Follow-Up:** Measures the number of patients who receive a follow-up call after their visit to the practice/clinic

- Clinical KPIs generally relate to quality performance and measure reporting (e.g., MACRA).

Quality Assurance Markers

- Optimal patient health
- Practice/Clinic growth
- Revenue targets:
  - increase outside referrals
  - increase follow-up appointments (e.g., prescription refills)

- Defined revenue targets provides practice goals.
- When monitoring these goals, trends will become apparent which should be analyzed.
- Take corrective action, if necessary.

Starting Point: KPI Monitoring

- **Cash Receipts:** Money that is collected and deposited in the bank should be monitored daily
- **Charges:** Fluctuations in charges should be monitored, as this directly correlates with fluctuations in cash receipts
- **Patient appointments:** Tracking the number of filled and unfilled patient appointments daily leads to operational efficiencies and aids in maintaining consisted monthly charges consistent, resulting in a steady, reliable cash flow
- **No show and patient cancellation rates:** This indicator aids in determining opportunities to improve capacity management and scheduling optimization

- These basic KPIs are functions which can be performed through system reporting.
- Charges and cash receipts require careful oversight.

Action Steps

1. Decide what quality assurance marker will be measured or what the practice/clinic would like to achieve
2. Choose how the quality assurance marker or goal will be measured (e.g., new patient numbers, average visit reimbursement, cancellation numbers)
3. Track the data month to month
4. Select another quality assurance marker or practice/clinic goal if the data has improved. Take corrective action steps and implement changes if the data has not improved

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- It is essential to create a tracking mechanism to report results (e.g., spreadsheet).

Finance Measures for Medical Billing

- Gap between date-of-service and date billed
- Percentage of claims denied due to front-end edits vs. due to coding errors
- Percentage of claims denied due to authorization/referral, insurance information or eligibility errors
- Collection KPIs Days Accounts Receivable (A/R) Net percentage collected, overall and by payer
- Percentage of claims denied overall, and by payer
- Percentage of no-response claims overall, and by payer
- Average life of denials and no-response incidents
- Denials by category

- Negative trends may need to be addressed by evaluating and updating office processes.
- Staff may require re-training to reduce these issues.

Sample KPI Report

Physician Group

Key Indicator Report

Date

	January	February	March	April	May	June	July	August	September
Office Related									
wRVU/Provider:									
Provider 1									
Provider 2									
Encounters:									
Per Day									
Per Provider									
Visit Code Ratios:									
New Patients									
Established Patients									
New Patient %									
No-Show Rate									
TOS (Cash) Collections									
Billing Related									
Charge Entry Lag									
Days in AR									
AR Over 120 Days									
Collection Ratio									
Self Pay %									

- This sample template can be utilized by any practice/clinic for monitoring various KPIs.
- This information will provide a robust overview of the practice/clinic.

Financial Reports

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Financial Reports

Daily

- Review daily activity and net production (Charges – payments – adjustments + Refunds, etc.)
- Quantify billing backlog
- Balance over-the-counter collections by source (cash, checks, remittance received, credit cards, etc.)

Weekly

- Quantify payment posting backlog
- Quantify collection backlog
- Quantify underpayments

Monthly

- Review outstanding A/R (billed, value and days)
- Review monthly production by provider
- Review denial activity during month
- Review reverse aging of payments

- Financial reports generate help analyze the practice/clinic's billing functions.
- Utilize the reports from your clearinghouse, which are especially useful for identifying denial trends.

Common Billing Pitfalls

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Patient Information

- Obtaining the most accurate and up-to-date information at the time of appointment scheduling and patient registration, will provide the groundwork by which claims can be billed and collected in the most efficient and effective manner possible
- Health insurance status and coverage must be verified at each patient encounter

- If patient information is entered incorrect when initially received, the claim cycle can be delayed for months before the error is identified and corrected..
- The format of Medicare beneficiary cards has been changed. Staff should be trained to ask for the new cards and enter the updated information into the PM system for billing purposes.

Financial Responsibility

- Implement clear financial policies which include:
  - Estimating costs of services
  - Informing patients about their financial responsibility
  - Making every attempt to collect monies towards patient balance at each encounter

- Ensure that there are office policies and procedures in place regarding patient collection of copays, coinsurance, and other patient responsibilities.
- Designate and train staff to assist patients with questions concerning their health coverage.

Claims Management

- Streamline denials management procedures with a clear delineation of tasks
- Automating the medical billing and claims management processes to help retrieve reimbursements from rejections and denials in a timely fashion
- Automation reduces inaccuracies (e.g., claim scrubber software)

- Learn about and utilize the full functionality of your PM system and clearinghouse for claims management.
- Designate a staff member to be a system “super user.”

Coding

Common issues in medical coding which can lead to an increase in claim denials:

- ICD-10 diagnosis codes not assigned to the highest level of specificity
- Incomplete or missing medical record documentation
- Failure to assign updated code sets
- Overcoding and undercoding of evaluation and management (E/M) services
- Unbundling/National Correct Coding Initiative (NCCI) edits

- Management must stay abreast of coding and regulatory changes within your specialty.
- An experienced staff coder should review charts. If a coder is not available, consider utilizing an outside coding vendor.

Billing Financial Reconciliation Processes

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Step 1: Daily Cross-Reference

- End of day totals:
  - Reconcile cash and A/R balances
  - Generate a report of the "Daily Patient Totals" itemizing each patient encounter, including diagnosis, procedure and treatment codes, performed and billed for the day
- Generate a report summarizing "total billing" for each patient for the day. This total should match the itemized patient encounter report, which is a report listing all the services provided for each patient for the day

Reports are only as accurate as all users' data entry. Ensure proper training and monitoring of staff .

- Reconciliation must be performed consistently.
- Many of these processes can be performed by utilizing a PM system.

Step 2: Billing Components Total

- Billing components include:
  - Cash sum
  - Checks and credit card receipts collected for out-of-pocket fees (co-pays and deductibles)
  - Daily Claim Total (amount the practice/clinic submits to the clearinghouse)
- All of daily billing components must equal to the:
  - Daily Transaction Total
  - Daily Patient Total

    This important cross-reference step is the central control point for the entire cash reconciliation process and patient A/R balance system
- Account for rejected claims

- Set policies for all monies collected at point of service.
- The practice should enforce timely medical record completion by providers (e.g; 24-48 hours).

Step 3: Track Reimbursement Components

- Post payments upon receipt
- Post each patient transaction code *by line item* with careful attention to variations in the previously determined copays and deductibles amounts
- The "allowed" amounts by the payer for each transaction code may require a write-off (based on payer contract) or account balances which the practice/clinic must resubmit to the clearinghouse as secondary or tertiary claims

- Receipts should not be deposited until they are properly entered in the PM system.
- A system report should be generated and reconciled to the bank deposit.
- Enter the contracted allowed amounts by carrier and CPT code in the PM system for more accurate posting and tracking.

Credentialing

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Recredentialing

- Ensure the practice/clinic's credentialing workflow maintains up-to-date documentation and licensure for recredentialing purposes
  - Develop a credentialing grid with "expirables management" reminders for:
    - State License
    - Drug Enforcement Administration (DEA) License
    - Payer contract term
- Work closely with your Human Resource Department to ensure that provider files are up-to-date
- Review denials and adjustments due to credentialing issues
- Accurately record the reason for all denied claims, as well as the number of accounts written-off due to incomplete credentialing status. This information will provide beneficial insight when recredentialing providers

- In Module 1, we recommended that a spreadsheet be maintained with provider information. This spreadsheet will be useful for the recredentialing process.
- Ensure that all licenses and current. Set reminders for upcoming expiration dates and alert providers.

Bell Curve Monitoring

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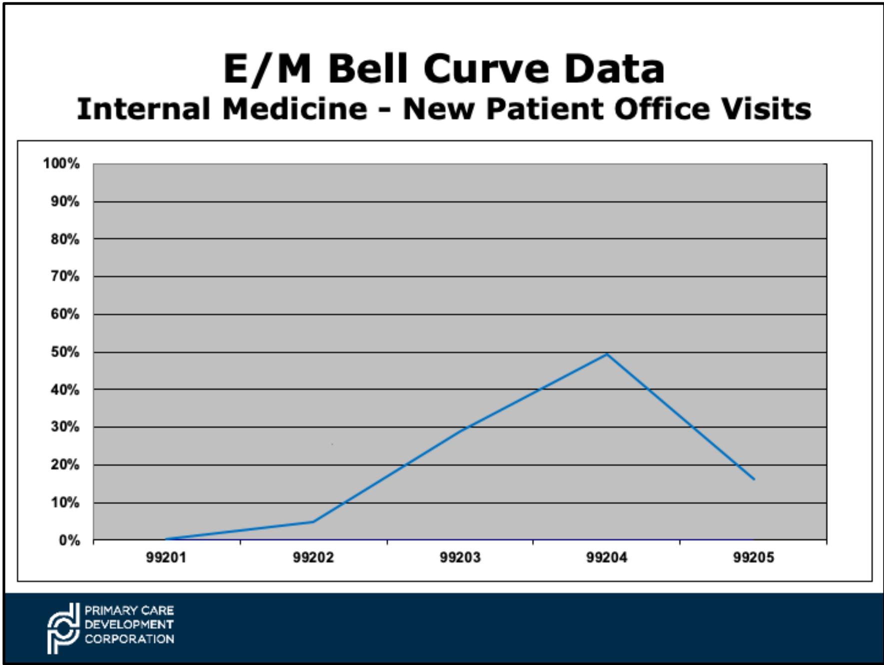
E/M Services

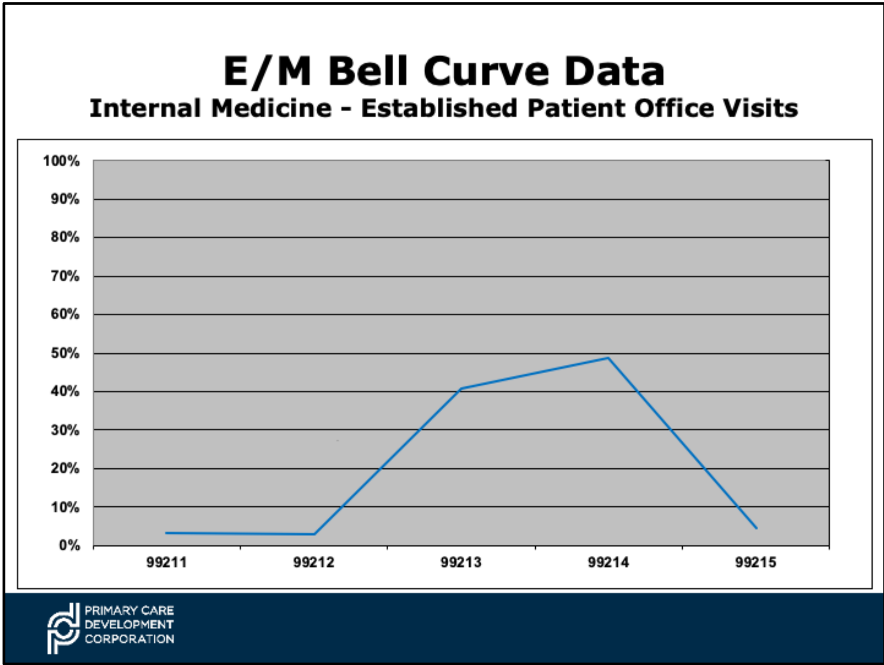
Evaluation and management (E/M) services are an ongoing focus of the federal payers.

- Lack of Medical Necessity
- Overcoding or Undercoding
- Incorrect E/M code category
- Consult requirements not met
- Preventive service should have been billed
- Chief Complaint missing or not clearly stated
- Assessment and/or Plan not clearly documented
- Time not documented correctly
- Documentation not authenticated
- Tests ordered and billed but not documented

- E/M levels of services must be carefully monitored to avoid potential risk areas.
- Ongoing provider and staff education regarding coding guidelines is essential.



- Medicare provides annual nationwide bell curve data for all recognized specialties.
- Bell curve data is utilized by carriers to determine if providers are billing outside the national trend for their specialty.



- This bell curve data for the same code set for a different specialty (example – Psychiatry) will appear very different than what you are seeing for Internal Medicine.

E/M Services

- Generate E/M Bell Curve data for each provider and compare to the group to identify outliers
- Perform coding QA of high level services (99214, 99215) prior to claim submission
- Perform annual provider education and training
- Monitor payer guidelines changes and updates

- Decision Health publishes Bell Curve data on an annual basis.
- The software program allows practices/clinics to input their productivity data and provide a comparison.
- The bell curve data should be compared as follows: The group against the national data, and each individual provider against the group. This will allow you to identify outliers.

Case Study

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E/M Services

Scenario: A patient underwent a left inguinal hernia (LIH) repair Tuesday morning. The physician writes an order to place the patient in observation following surgery for post-op pain control. The nurse documents the patient arrived in recovery at 11 a.m. There were no complications and no services rendered outside of the routine post-operative services. The physician discharged the patient at 11 p.m.

Can the facility bill for observational services?

Observation: Even though the patient was being observed for 12 hours, the facility cannot bill for observation services. The observation was part of the regular post-operative treatment and should be billed as recovery room services. If the physician documented a post-operative complication, then it would be billable. Since the patient is placed in observation because of a complication, the facility can bill for observation as long as the physician writes an order and the nurse documents the start and stop time for the observation.

Inc. (2019, January 15). Retrieved from http://www.hcpro.com/HIM-285489-8160/Use-case-studies-to-explore-observation-services.html

Session Highlights

- Understanding KPIs as measurement tools to monitor various aspects of the practice/clinic for efficiencies
- Critical KPIs to focus on to ensure the practice/clinic is working at an optimal level
- The use of financial reporting to assist in monitoring the KPI measures for the Medical Billing Office
- Financial reconciliation processes allowing for better controls and monitoring
- The importance of maintaining an up-to-date credentialing process to ensure cash flow and facilitate recredentialing of providers
- Understanding the importance of bell curve data and E/M related risks

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Session 4 Discussion and Series Conclusion

- KPI selection for your practice/clinic
- Reconciliation process you can implement immediately
- E/M related concerns you may have for your practice/clinic
- Topic review/questions from Sessions 1, 2 or 3

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