



Managing the Revenue Cycle Process

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Revenue Cycle Benchmarks

- Days Outstanding / Days in A/R
- % of A/R Greater than 90 Days
- Claim Lag / Billing Lag
- **Net Collection Rate**
- Gross Collection Rate

Days Outstanding/ Days in AR

- Definition: In its most basic form, Days Outstanding is essentially the time it takes to get a claim paid
- Calculation: $\text{Total AR} / (\text{total charges from last 3 months} / 90)$
- Acuet Standard: Less than 30 Days
- Uses: Determines the health of your AR. Wild swings from month-to-month may highlight a billing or collection problem

% of A/R Greater than 90 Days

- Definition: The amount of \$\$ as it relates to total AR greater than 90 days outstanding
- Calculation: $\text{Total AR greater than 90 days} / \text{Total AR}$
- Acuet Standard: Less than 15%
- Uses: High % of AR greater than 90 days may emphasize an issue with patient collections or insurance denials

Claim Lag/ Billing Lag

- Definition: The time it takes to get a claim sent (billed)
- Calculation: Number of days from DOS to charge entry / submission
- Acuet Standard: Less than 3 Days
- Uses: Determines how quickly charges are being sent. A high Claim/ Charge Lag has a negative impact on Days Outstanding

Gross Collection Rate

- Definition: The % of total charges the facility collected
- Calculation: $\text{Total payments} / \text{total charges}$
- Acuet Standard: ?????
- Uses: Cannot use to benchmark, but may be useful in comparing month-to-month in the same facility to identify trends

Net Collection Rate

- Definition: The % of eligible \$\$ the facility actually collected
- Calculation: $\text{Total payments} / (\text{total charge} - \text{contractual} - \text{bad debt} + \text{refunds})$
- Acuet Standard: Greater than 97%
- Uses: Determines how well business office staff collect on contracted amounts/
how much \$\$ is left on the table

Audit Types

Some of the most common types of business office audits include:

- **Billing:** billing lag, modifiers
- **Denials:** compare to previous months, communicate to front-end
- **Follow-up:** consistent, relevant, correct?
- **Payment Posting:** line item, proper steps on underpayments, denials
- **Coding:** correct codes being billed supported by documentation
- **Reimbursement:** paid correctly?

Reimbursement Audits

- Reimbursement Audits are the most common – conducted to determine if the facility was paid what was contractually owed or sufficiently (OON) by a third party on billed CPT codes
- Associated RCM Metrics: Days Outstanding, % A/R > 90, Net Collection Rate
- Should be conducted regularly: weekly or bi-monthly at a minimum
- Must be proficient with payer contracts, rules, carve-outs, multiple procedure discounts, state, federal and or payer laws
- Will not address incorrect billing or coding

Reimbursement Audits – Steps

1. Determine sample size
 - Size will be dependent on frequency of audit
 - The more frequent the audit, the smaller the sample size
2. Run report(s) with the following data elements:
 - Unique identifier: Acct #, Visit #, MRN
 - Contractual
 - Payment
 - Balance

Reimbursement Audits – Steps

3. Review payer contract(s)
 - Fee schedule
 - Carve-outs
 - Multiple procedure discounts (MPD)
 - Implants

Reimbursement Audits – Steps

5. Perform audit on all \$0 balance visits
 - Compare payment amounts per CPT to contractual rates, taking into account carve-outs, MPDs, and implant reimbursement (if applicable)
 - If variance exists, calculate the underpayment amount and the **Net Collection Rate**
6. Analyze results
 - If NCR is less than 97%, determine root cause(s)
 - Low NCR may necessitate further analysis, such as a follow-up and/or payment posting audit

Conclusion

- *A practice or facility may have gold standard metrics, but be “cash poor”*
- *Utilize different types of business office audits to determine the true health of an organization*



Thank You!

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Credentialing & Provider Enrollment

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What is Credentialing & Provider Enrollment

- Gathering and verifying credentials for the entity, physicians and medical professionals under the Tax ID to ensure services will be safely and appropriately rendered
- Process of enabling medical physicians and professionals to participate in healthcare insurance networks while being reimbursed for their services provided under contractually agreed upon rates

Importance of Credentialing & Provider Enrollment

- Healthcare Insurance Networks now require in-depth, lengthy enrollment processes for most physician types, across all specialty areas
- Healthcare Insurance Networks frequently update and add new requirements to the enrollment process making accuracy of application submissions vital to prompt approvals
- Extended processing times for enrollments can create potential net collection revenue loss as physicians wait to become approved and in-network
- Specific demographic details, such as service locations, may affect reimbursement based on where physicians render services
- Not maintaining enrollment accuracy will cause non-compliance with contractual obligations, therefore resulting in loss of revenue

Credentialing & Revenue Cycle Process

- Credentialing has a direct impact on the steady flow of reimbursement and is one of the leading causes of financial loss
- Utilize different business office audits to help identify areas of revenue reduction due to credentialing issues as well as identify compliance gaps
- Maintaining a transparent and up to date listing of each physician's Healthcare Insurance Network status will increase revenue and allow staff to deliver the highest level of care for all patients

Denial Audits

- Denial audits can help pinpoint possible credentialing inconsistencies
- As inconsistencies are found, it is vital for swift communication to appropriate staff in order to update the physicians approved Healthcare Payer status
- Credentialing is often an extensive and lengthy process, which can cause an influx of denials without proper communication
- Common Denials that usually highlight Credentialing Issues
 - Out of Network
 - Lack of Prior Authorization
 - Invalid Place of Service

Reimbursement Audits

- Reimbursement audits help to identify if the practice and/or physicians are being paid correctly
- Each Healthcare Payer has a Contracted Fee Schedule that is agreed upon when the contract is executed during the process of becoming an In-Network, Participating practice and/or physician
- Many times, when payments are not being compensated to this contracted fee schedule, it is due to an issue with the enrollment
- Additional Service Locations can also impact reimbursement totals as they are not considered in-network under the executed contract if not credentialed properly

Summary of Credentialing Key Points

- Credentialing and Provider Enrollment are quickly growing to become major complex processes within every medical entity but are often overlooked or pushed to the side
- Compliant Provider Enrollment will positively impact the management of the Revenue Cycle process leading to more productive and accurate reporting
- Missed credentialing details will lead to inconsistent revenue with limited recourse for recoupment of lost funds

Be proactive, not reactive
to ensure credentialing compliance
eliminating loss of revenue
that could have been collected!



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Which is Best?

In the list of hypothetical ASC's below, assuming charge masters are the same, which one is in the best financial position and why?

- Days in A/R – 35.0; Net Collection Rate – 97%; Percent A/R > 90 – 11%; Gross Collection Rate – 69%
- Days in A/R – 23.0; Net Collection Rate – 99%; Percent A/R > 90 – 6%; Gross Collection Rate – 63%
- Days in A/R – 40.0; Net Collection Rate – 92%; Percent A/R > 90 – 16%; Gross Collection Rate – 74%