Strategies for Revenue Cycle Management Success

APRIL 26, 2024

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SPEAKERS

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Revenue Cycle Management (RCM) Defined

- A wholistic multidisciplinary approach recognizing that information needed prior to admission has significant impact on collection
- Financial process of collecting payments for medical bills to generate revenue for a healthcare organization
  - Process that begins before a resident admission and ends when all claims are paid
- Combines administrative data, such as a patient's personal information, insurer name and treatment codes, with billing information and clinical information and documentation
- RCM involves numerous individuals and departments
- Centralized approach ensures more reliable reimbursement, compliance, and clinical processes

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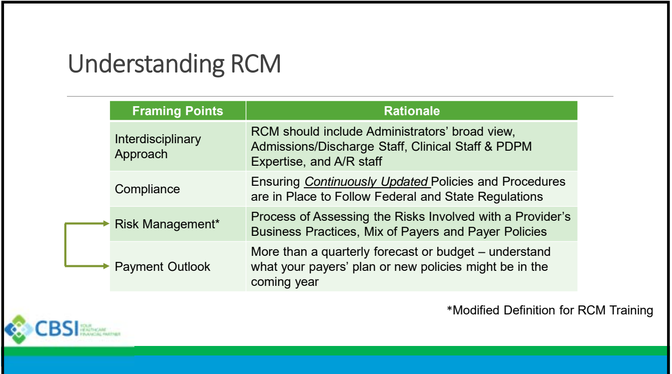

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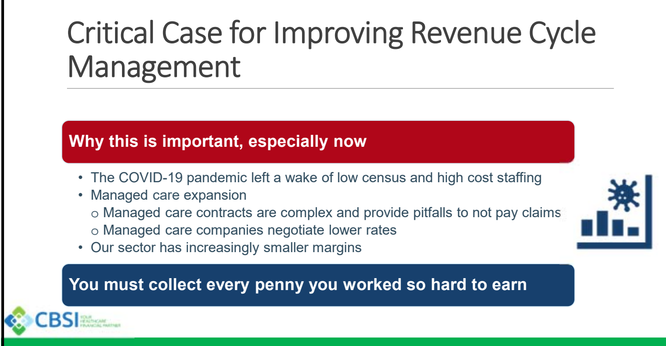

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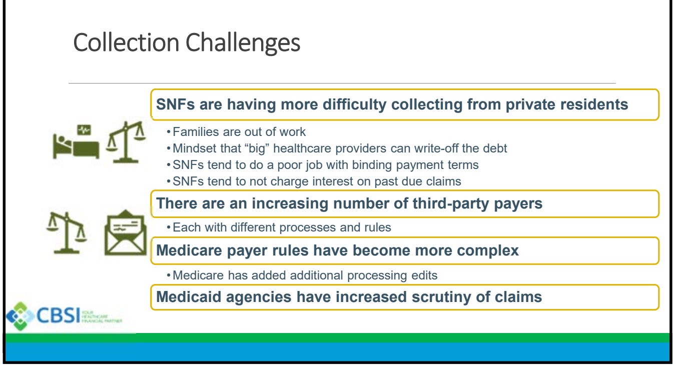

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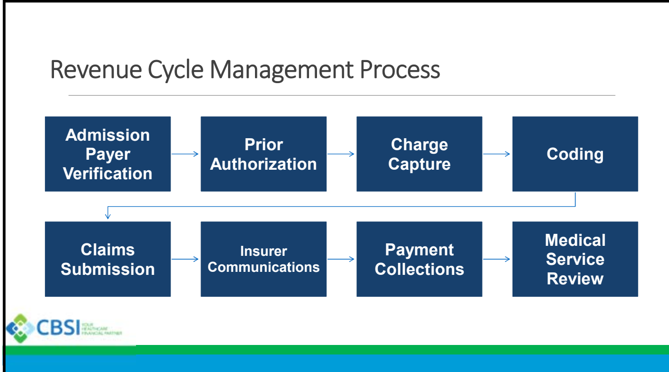

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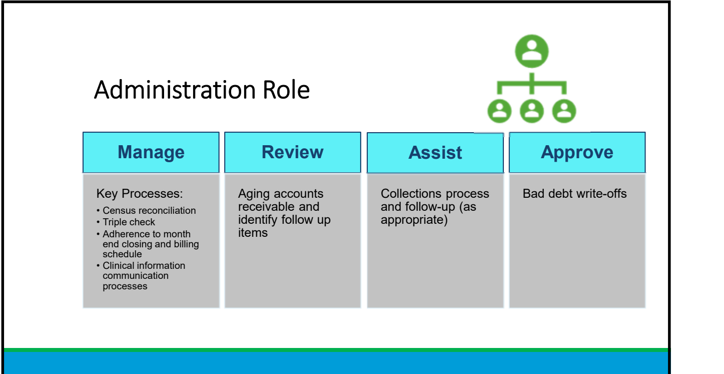

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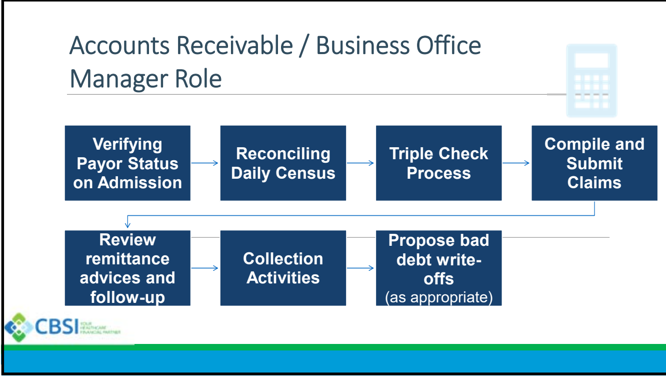

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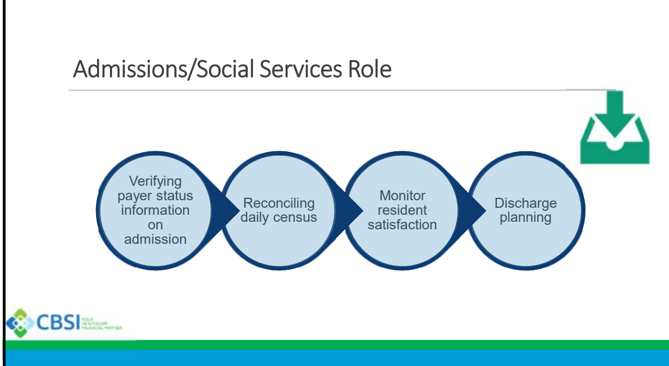

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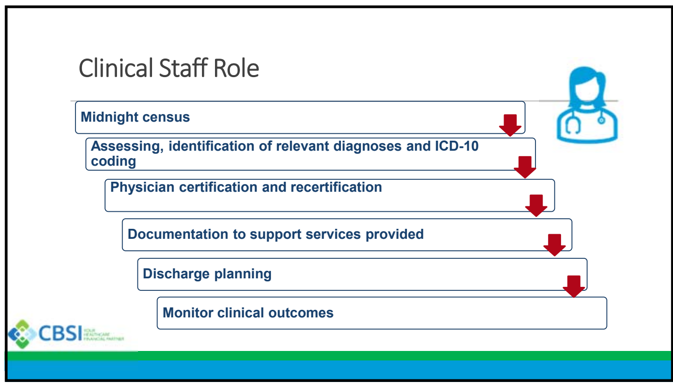

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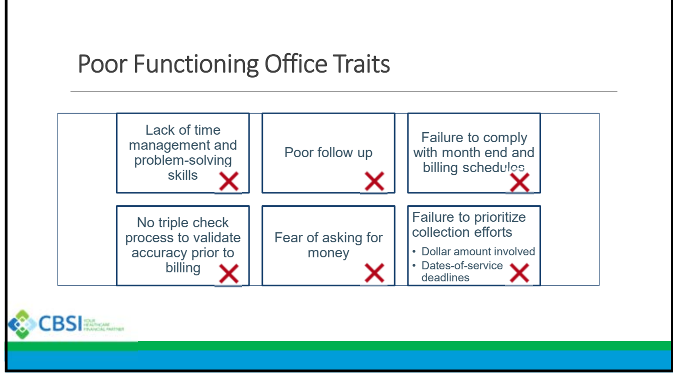

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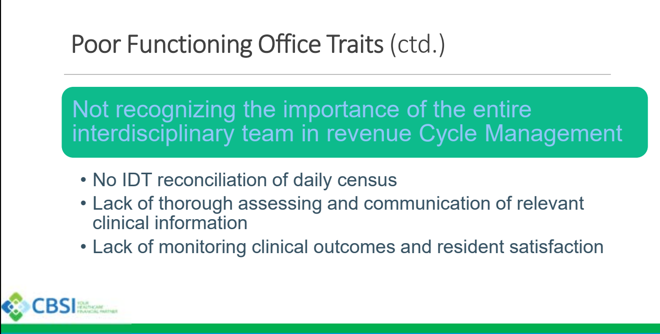

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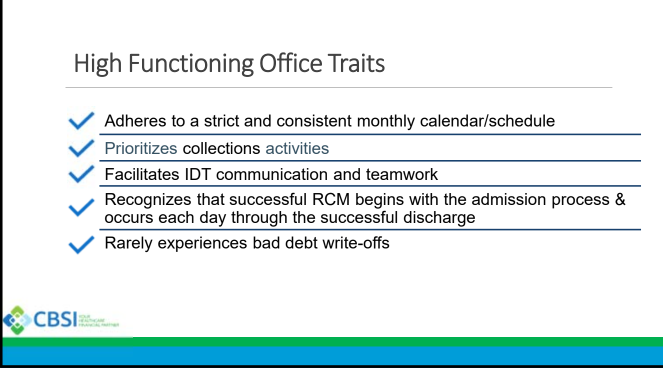

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Time Management and Revenue Cycle Management

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Time Management Skills

Time management and scheduling is one of the most critical problems to solve for successful revenue cycle management

- Scheduling
- Prioritizing
- Delegating
- Goal setting
- Strategic thinking
- Work smarter; not harder

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Time Management and RCM

- Plan and schedule the activities that must occur throughout the month
  - Admissions and discharges
  - Assessing, ICD10 coding, triple check
  - Census reconciliation
  - Capturing ancillary charges
  - Month-end close
  - Billing
  - A/R reviews
  - Follow up and collections

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Work Smarter; Not Harder

- Electronic billing to all payers through interface with provider software
- Electronic upload of all payer remits
- Upload Ancillary charges into Provider Software
- Reduce or eliminate manual entry
  - Takes time
  - Everyone makes mistakes
- General rule: one input; many uses

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Monthly Schedule for RCM

- **Daily**
  - Census changes [admissions, discharges, room moves, payer changes]
  - Post money received in billing software
  - Assure money is deposited in bank
  - Check for pending or rejected claims online
  - Provide insurance updates as required
- **Weekly**
  - Follow up on past due claims by payer with collection calls or letters
  - Triple check completed Medicare 5-day assessments prior to submission

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Monthly RCM Billing Flow

- ✓ Import/Enter Charges
- ✓ Run trial claims
- ✓ Triple Check
- ✓ Send Private Statements
- ✓ Billing all payors
- ✓ Reconciled deposits received
- ✓ Close AR software

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Ensuring Accurate & Adequate Payment

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Staff Interactions
The Medicare Huddle

- **Clinical processes & information increasingly impact successful RCM**
  - HIPPS codes from assessments determine payment rates
  - Clinical information must be reported on claims
  - Inconsistency between assessments and claims can lead to denials
- **An interdisciplinary huddle should discuss all short stay residents, including Part A beneficiaries; this huddle should include**
  - DON and MDS Coordinator
  - Rehab Director, Nutrition Services, Social Services
  - Administrator, Business Office Manager

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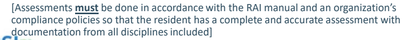
Staff Interactions
Purpose of the Medicare Huddle

- Thorough, complete, and accurate 5-day assessment
- Consistency in documentation between all disciplines
- Consistency in diagnosis coding between the MDS and Medicare claim
- Evaluate the beneficiary's clinical progress throughout the stay and monitor for potential Interim Payment Assessments
- Evaluate the beneficiary's progress toward their self-care and mobility goals throughout the stay
- Perform ongoing utilization reviews



[Assessments **must** be done in accordance with the RAI manual and an organization's compliance policies so that the resident has a complete and accurate assessment with documentation from all disciplines included]

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Staff Interactions
The Medicare Huddle – New Admissions

- Topics for discussion should include:
  - Communicate ARD selected for the 5-day assessment
  - Discuss clinical drivers used in PDPM rate
    - Primary reason for the SNF stay
    - Diagnoses that could impact the SLP comorbidities, nursing and NTA components
    - Results from resident interviews
    - "Usual" self-care and mobility performance during the first three days of the stay
    - Goals for the resident to achieve during the part A stay
  - IDT review of key MDS items prior to closing the assessment
    - Utilize the PDPM analysis tool in clinical software as a reference

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Staff Interactions
The Medicare Huddle

- Topics for discussion throughout the stay
  - How is the beneficiary progressing clinically?
    - Discuss services provided outside the SNF
    - Monitor for potential Interim Payment Assessments
    - Monitor to avoid SNF QRP negative outcomes
    - Provide status reports to family
  - If the beneficiary discharges and returns, discuss if it meets the criteria for an interrupted stay or a new stay with a new 5-day assessment
  - How is the beneficiary progressing toward self-care and mobility goals
  - Discharge planning

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Admissions Process Do's & Don'ts
Exercise

Do follow an admission checklist. Every. Single. Time.
Do have a summary of all insurance contracts and review prior to admission
Do obtain prior authorizations when required
Do copy all insurance cards for financial file
Do conduct Medicare Secondary Payor (MSP) screening and verify remaining days in a benefit period

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Admissions Process Do's & Don'ts
Exercise

- Do review hospital medical records to identify need for skilled care, if applicable, and to begin PDPM data collection process
- Do verify Medicaid eligibility status and determine if/when family will need assistance with the application process
- Do ensure responsible party understands the billing process and your facility's expectations for payment
- Do follow your policy for charging interest and collecting payment from the very first month

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Admissions Process Do's & Don'ts
Exercise

Don't have the philosophy to get the head in the bed first and figure the rest out later

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Staff Interactions
Accurate Daily Census

- An accurate daily midnight census is **critical**
- The IDT should reconcile census daily to identify admissions, discharges, leave of absence, payor changes
- Each resident's medical record should accurately reflect the date and time of any admission or readmission, discharge or leave of absence
- Nursing should conduct a midnight head count every night to identify any residents not in the facility at midnight

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Accurate Daily Census
Common Problems

Discharge vs. Leave of Absence

- Discharge:
  - Resident is being discharged home or to a lower level of care
  - Resident is ADMITTED to the hospital
  - Resident is in a hospital observation stay > 24 hours
- Leave of absence
  - Resident is on a temporary home visit or therapeutic leave
  - Resident is sent to the hospital, is not admitted, returns < 24 hours

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Accurate Daily Census
Common Problems

- **Interrupted Stay vs. Part A PPS Discharge**
  - If a Part A beneficiary discharges, **but returns to the same** SNF within **three midnights**, this is an interrupted stay.
    - Discharge assessment and re-entry tracking form are required
    - Billing continues based on the previously completed 5-day assessment, unless the facility chooses to complete an optional Interim Payment Assessment
    - The beneficiary continues on the previous schedule related to the Variable Per Diem rate Adjustment under PDPM
    - The facility should continue with the previously started schedule for physician certifications and recertifications of the need for skilled care, even if an IPA is completed

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Accurate Daily Census
Common Problems

Interrupted Stay vs. Part A PPS Discharge

- If a Part A beneficiary discharges **and returns after the third midnight**, the original stay ends and a new stay begins when they return
  - Discharge assessment, re-entry tracking & a new 5-day assessment all required
  - Beneficiary starts over on day one under the Variable Per Diem Rate Adjustment schedule under PDPM
  - This is considered a **new** Part A stay
    - A new physician certification of need for skilled care is required, followed by a recertification by day 14 of the new stay and every 30 days thereafter

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Accurate Daily Census
Common Problems

- **Reviewing bed hold status when a resident leaves the facility**
  - Is the family paying to hold the bed?
  - Will Medicaid cover the bed hold days?
- **Communicating payor source changes and updating records**
  - Transition between Medicare Advantage and traditional Medicare
  - Applications for Medicaid
  - Medicaid effective dates
  - Changes in insurance coverage

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Diagnosis Coding and the MDS

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ICD-10 Diagnosis Coding on the MDS

Condition requires a physician-documented diagnosis in the last 60 days.

- The coder should review:
  - ✓ Progress notes
  - ✓ History and physical
  - ✓ Transfer documents
  - ✓ Discharge summaries
  - ✓ Diagnosis problem lists [confirmed by physician]

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ICD-10 Diagnosis Coding on the MDS

- Determine if diagnosis is active **[7-day lookback]**
  - Direct relationship to the residents current functional, cognitive, mood or behavior, medical treatments, nursing monitoring or risk of death
  - Only include diagnosis that either impact the resident's current status or drive the resident's care plan

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Diagnosis Coding is a 10 Step Process

1. Upon admission, collect all physician documented diagnoses in the last 60 days from the acute hospital stay.
2. Determine which codes are active in the last 7 days based on which diagnoses have a direct relationship to the residents plan of care
3. Determine primary reason for SNF admission and select appropriate diagnosis code [primary diagnosis]. Also known as principle diagnosis.
4. Prioritize and sequence remaining active diagnoses
5. Assign and record the appropriate diagnosis code to each active and historical medical diagnosis using current and official ICD-10-CM code set

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Diagnosis Coding is a 10 Step Process

6. Complete and maintain active diagnosis list either electronically or via manual means
7. Complete the MDS - Section I and Section J check boxes based on active diagnosis list
8. Complete MDS Section I8000 with remaining codes not identified via MDS check boxes
9. Determine diagnosis codes to be used on UB-04
10. During resident's stay, update and maintain the active diagnosis list as necessary

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Diagnosis Coding on the MDS

- Check the appropriate box I0100 through I7900
- Use I8000 If a disease is not specifically listed in the above section or to provide a more specific ICD-10 code
  - Enter the diagnosis and ICD10 code
- Z codes or after care may be used but only to expand on a primary medical condition already marked in section I

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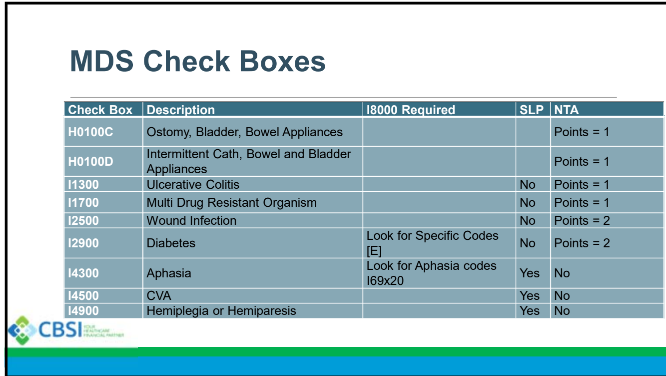

MDS Check Boxes

Check Box	Description	I8000 Required	SLP	NTA
H0100C	Ostomy, Bladder, Bowel Appliances			Points = 1
H0100D	Intermittent Cath, Bowel and Bladder Appliances			Points = 1
I1300	Ulcerative Colitis		No	Points = 1
I1700	Multi Drug Resistant Organism		No	Points = 1
I2500	Wound Infection		No	Points = 2
I2900	Diabetes	Look for Specific Codes [E]	No	Points = 2
I4300	Aphasia	Look for Aphasia codes I69x20	Yes	No
I4500	CVA		Yes	No
I4900	Hemiplegia or Hemiparesis		Yes	No

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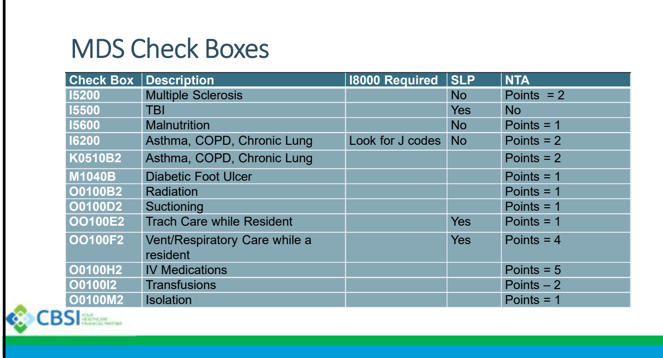

MDS Check Boxes

Check Box	Description	I8000 Required	SLP	NTA
I5200	Multiple Sclerosis		No	Points = 2
I5500	TBI		Yes	No
I5600	Malnutrition		No	Points = 1
I6200	Asthma, COPD, Chronic Lung	Look for J codes	No	Points = 2
K0510B2	Asthma, COPD, Chronic Lung			Points = 2
M1040B	Diabetic Foot Ulcer			Points = 1
O0100B2	Radiation			Points = 1
O0100D2	Suctioning			Points = 1
OO100E2	Trach Care while Resident		Yes	Points = 1
OO100F2	Vent/Respiratory Care while a resident		Yes	Points = 4
O0100H2	IV Medications			Points = 5
O0100I2	Transfusions			Points – 2
O0100M2	Isolation			Points = 1

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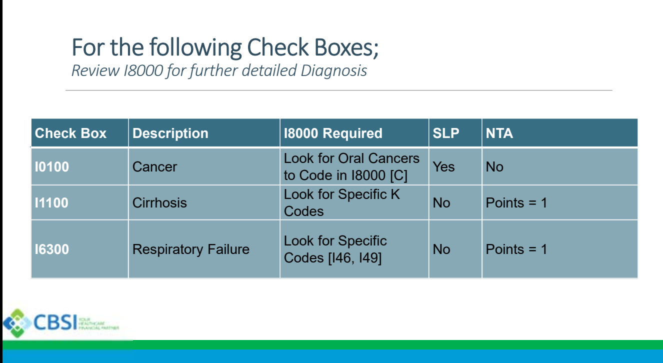

For the following Check Boxes;

Review I8000 for further detailed Diagnosis

Check Box	Description	I8000 Required	SLP	NTA
I0100	Cancer	Look for Oral Cancers to Code in I8000 [C]	Yes	No
I1100	Cirrhosis	Look for Specific K Codes	No	Points = 1
I6300	Respiratory Failure	Look for Specific Codes [I46, I49]	No	Points = 1

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PDPM & ICD-10 Coding Tips

- Different components under PDPM look at different MDS items, you may need to code the same diagnosis or condition in more than one place to get credit in each component
- For an admission with Acute Respiratory Failure with Hypoxia
  - I0020B = J96.01 to get the correct PT and OT score
    - J96.01 maps to Medical Management
  - I6300 = checked to get the correct Nursing score
    - Respiratory Failure with oxygen while a resident = Special Care Low
  - I8000 = J96.01 to get the correct NTA score
    - Cardio-respiratory failure/shock = 1 NTA point

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PDPM & ICD-10 Coding Tips

- It is critical for the MDS Coordinator and the business Office Manager to reconcile the diagnoses that contributed to the PDPM HIPPS code with the ICD-10 codes to be used on the claim to ensure consistency

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UB-04 Tips

- Billing software should cross over correct HIPPS code from clinical to UB=04 FL 44
- Continue to use Rev Code 0022 in FL 42
- Continue to show MDS by ARD in Occurrence Code FL 31 -34
- Pay attention to Interrupted Stay Policy
- For HIV; continue to use ICD10 = B20 on UB-04
  - Nursing is increased 118%
  - NTA add 8 points

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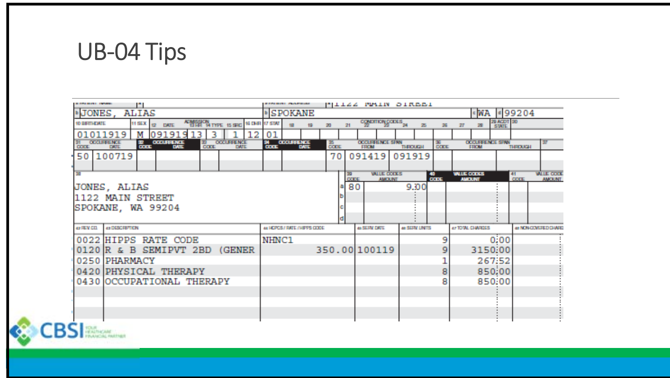
UB-04 Tips



JONES, ALIAS | SPOKANE | WA | 99204

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
01011919	M	091919	13	3	1	12	01

31 CODE	31 OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH
50	100719	70	091419	091919

JONES, ALIAS
1122 MAIN STREET
SPOKANE, WA 99204

39 VALUE CODES CODE	AMOUNT
80	9.00

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0022	HIPPS RATE CODE	NHNC1		9	0.00	
0120	R & B SEMIPVT 2BD (GENER	350.00	100119	9	3150.00	
0250	PHARMACY			1	267.52	
0420	PHYSICAL THERAPY			8	850.00	
0430	OCCUPATIONAL THERAPY			8	850.00	

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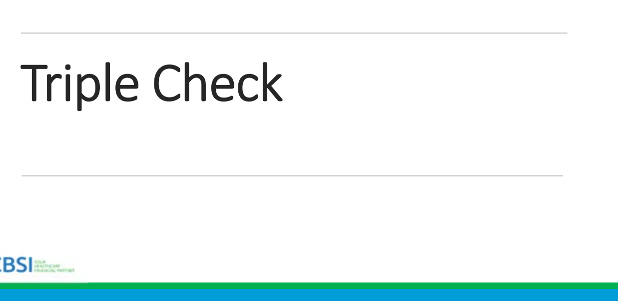

Triple Check

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Triple Check
What it is

- Each month prior to transmitting claims to third party payers (Medicare, HMO etc.) a Triple Check is completed in accordance with facility policy and procedure
- Oversite & peer review outcomes of those departments that impact the amounts billed to payers
- Assure clean & accurate claims are submitted to all payers.
- Verify physician certification/recertification is signed by physician and define reason for skilled treatment
- Not the time to verify the accuracy of the MDS

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Triple Check
What it is not

- Tasks done prior to triple check by staff/department responsible
  - Verify accuracy of MDS, including therapy minutes
  - Verify Medicare charting is completed by all disciplines
  - Verify physician orders are complete for all skilled services provided
  - MSP form filled out, signed & included in resident financial folder
  - Admission agreement signed & included in resident financial folder
  - All ancillary charges are entered in software prior to creating UB04s for triple check

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Triple Check
Tasks

- **Common Working File/Eligibility Checks**
  - Beneficiary name, MBI number, date of birth, match the CWF or eligibility check for HMOs
  - Number of available SNF benefit days & correct dates of hospital stay
  - Traditional Medicare vs. Medicare Advantage enrollment

Census
- Correct admission & billing dates
- Verify billing & patient status

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Triple Check
Tasks

- **MDS**
  - Verify MDS transmitted & accepted
  - HIPPS code is correct for each revenue code 0022 line-item
  - Correct number of days billed for each HIPPS
  - Verify correct ARD date & HIPPS code for each one
  - Check for IPA

- **Diagnosis Codes**
  - Diagnosis in appropriate sequence and support the skilled care provided

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Triple Check
Tasks

- **Therapy**
  - Billed units match therapy log
  - Make sure therapy diagnosis are also included in diagnosis list
- **Ancillaries**
  - Verify pharmacy, lab, x-ray, etc. are on UB04 with correct revenue codes

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Putting Methods into Practice

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10 Best Billing Practices

1. Assure admission process is thorough and that resident and family understands what will be owed
2. Collect Medicaid "share of costs" at time of admission to extent allowed by each state
3. Pre-bill private by 25th of month for following month
4. Include interest on past due account in admission agreement
5. Bill private co-insurance once services are rendered

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10 Best Billing Practices

6. Bill Medicare by 14th of the month to assure payment in same month
7. Assure daily critical habits include checking pending or rejected claim status
8. Assure segregation of duties when handling payments
9. Reconcile census daily to ensure admissions, readmissions interrupted stays, payor changes, bed hold days and discharges have been properly identified
10. Review assessments used for reimbursement prior to submission

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Policies and Procedures for Effective Aging Reviews

- Prioritize your review
  - Focus on larger and older balances first
  - If time permits, review remaining accounts
- Develop an action plan for each account needing follow up
  - What is the next step and who is responsible
  - Establish a deadline for completion
  - Schedule a mini review at each deadline established
- Be alert to trends or common problems and focus on systems

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Policies and Procedures for Effective Aging Reviews

- Utilize critical thinking skills – do the explanations make sense?
- Use notes from the initial aging review to target follow up discussions
- Assure “proper” amount of pressure is placed of private paying residents to pay

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Aging Reviews Do's & Don'ts

- Prioritize your review
  - Focus on larger and older balances first
  - If time permits, review remaining accounts
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Aging Reviews Do's & Don'ts

- Utilize critical thinking skills – do the explanations make sense?
- Use notes from the initial aging review to target follow up discussions
- Assure "proper" amount of pressure is placed of private paying residents to pay

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Billing Approach: SNF Case Example

- 99 Bed Skilled Nursing Facility
- Pre-Pandemic Census: 90 with 7 Medicare, 20 VA, 3 Managed and 60 Medicaid
- Census Today 63 with 7 Medicare, 4 VA; 52 Medicaid
- Financial 2020:
  - Revenue $9,644,287
  - Net Income ($117,242)
  - AR 2020: $1,161,000
  - Days Sales Outstanding: 44
- Today AR Total AR > 90 = $281,322 or 40.11%

Time Lags & Aged Claims Result in Case Flow Challenges

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Medicare
Medicaid
Manage Care

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Case Example: SNF Billing Approach

	Current	30	60	90	>90	Total
Private	$ 23,825	$ 30,988	$ 36,050	$ 42,830	$ 221,893	$ 355,586
Medicaid	$ 118,939	$ 8,656	$ 255	$ 3	$ (345)	$ 127,508
Medicare	$ 42,677	$ 23,465	$ 1,484	$ -	$ 6,126	$ 73,752
Medicare Adv	$ 18,528	$ 15,131	$ 5,991	$ 5,187	$ 1,188	$ 46,025
Managed Care	$ 17,160	$ 5,231	$ 5,936	$ 3,690	$ 747	$ 32,764
VA	$ 26,284	$ 24,974			$ -	$ 51,258
Other	$ 8,904	$ 5,585			$ (20)	$ 14,469
Total	$ 256,317	$ 114,030	$ 49,716	$ 51,710	$ 229,589	$ 701,362

Observations

1. Not collecting $33,000 / month in Private - 4.1% of revenue
2. Medicaid collections are mostly good
3. Medicare should pay claims 100% of claims on a 14-day floor
4. Medicare Advantage should be set up with EFT; they pay quicker
5. VA; unfortunately, this is about normal in this region

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Exercise: Mock Aging Review

Rate these answers: Should there be follow up?

- **Q1: Why didn't Medicare pay the claim?**
  - A: It was not billed timely
- **Q2: Why are we writing off $3,100 for Jane Doe from Medicare Advantage in July?**
  - A: AR was booked at the $600 / day and the contract is $500 / day
- **Q3: Why do we show "share of cost" for Medicaid as a write-off?**
  - A: Award letter issues retroactive and patient has discharged
- **Q4: Why is there a credit balance for Jane Doe of $3,000**
  - A: Patient paid co-insurance for days 21-30. Medicare paid for days 1-20

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Collections Beyond Billing

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Beyond Billing:
Four Pillars to RCM Success

1. Successful RCM starts prior to admission and continues until all amounts are collected
2. Set the stage for success prior to and during admission
   - The expectation of payment must be set
3. Ensure ongoing activities capture all needed information and documentation
4. Conduct effective aging reviews and claim follow-up

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Before Aging Review

- Assure all payments are posted
- Review notes from prior month aging review

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Set Aging Goals by Payer

- **Establish collection goals by payer:**
  - **Private** < 30 days
  - **Medicare** < 30 days
  - **Medicaid** < 30 days [Depending on state]
  - **Medicare Advantage** < 30 [Depending on contracts]
  - **Other** < 45 [Assure goal is based on electronic billing and payment by EFT]

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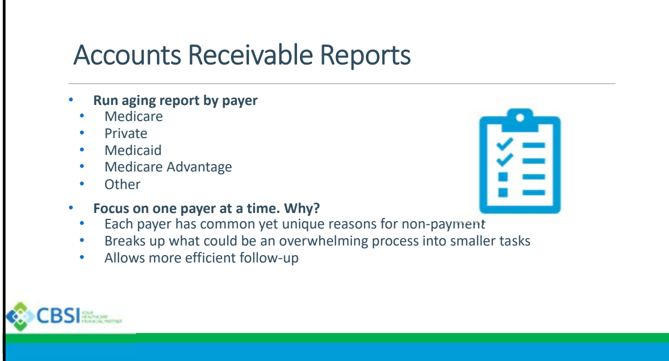

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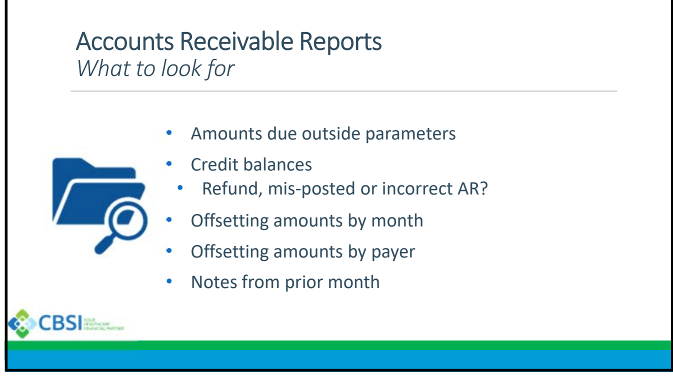

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