Healthcare Journey and Revenue Cycle White Paper

The Patient is Front & Center

The healthcare revenue cycle encompasses the entire life of a patient account, from the moment it is created until it is paid in full, and then it starts all over again on the next visit. At the bedside and beyond, the revenue cycle touches every aspect of a healthcare organization's clinical and financial operations. Therefore, successful management of the revenue cycle is vital to its health.

What is Revenue Cycle Management?

Healthcare Revenue Cycle Management (RCM) is defined as the financial process used by healthcare providers to administer all functions associated with patient service revenue throughout the entirety of a patient's care journey, from scheduling and account creation to billing and final payment. The cycle begins with patient pre-registration, followed by claim submission, and concludes with remittance processing.

The First Rule of Revenue Cycle Management: Start with the Patient

Like every aspect of healthcare, RCM starts with the patient. It's important to remember that the patient visit is only one small piece of the overall care experience. Before, after, and in between, most patient interactions are often NOT with physicians and nurses – they're with administrative or billing staff who may have no knowledge of the patient's clinical experience.

The healthcare landscape is constantly evolving. With the advent of patient consumerism and the transition to value-based care models, revenue cycle management is vital to a health system's fiscal fitness. Successful RCM programs can help hospitals and physicians achieve healthcare's Triple Aim – improving health of patient populations, creating a better care experience for patients, and reducing the cost of care.

Keep Patients Engaged Throughout the Revenue Cycle

It is important for a healthcare provider to actively guide a patient along the entire continuum of care – to facilitate a patient's journey on the road to recovery and a healthy life, and to expedite the process of receiving payment. But it doesn't happen automatically.

A patient's input is just as critical to the payment and administrative aspects of healthcare as it is to the clinical treatment. Consider this: Right now the patient is the No. 3 payor behind Medicare and Medicaid, and patient pay responsibility is anticipated to climb to 50% by the end of the decade.

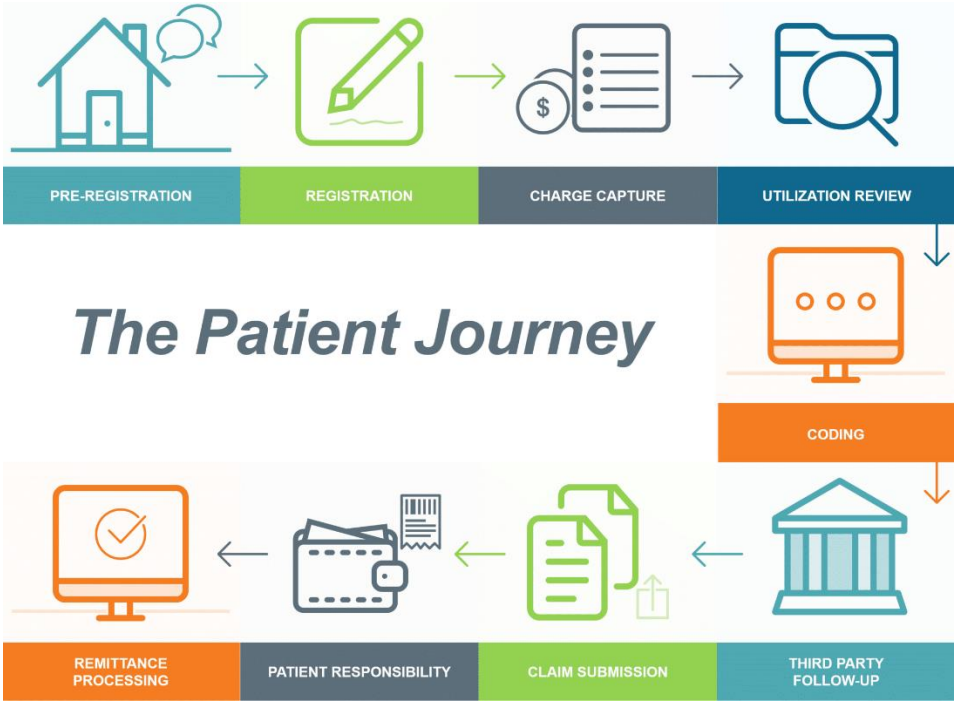
Yet, patient engagement can be challenging for hospitals and other types of healthcare providers. Each interaction between patient and provider – updating personal information on accounts, collecting co-payments, etc. – presents an opportunity to speed the process along or slam on the brakes. Too many forms, appointments, and bills can confuse and frustrate patients, decreasing their satisfaction with the overall healthcare experience.

The ability to efficiently and effectively manage all these parts of the revenue cycle, including assisting patients with paying medical bills for the care they received, plays a tremendous part in how much a hospital gets paid and how fast it happens. Quality RCM programs streamline the financial environment for the patient throughout their care journey, from start to finish.

RCM includes many steps along the financial path that require direct patient interaction, such as scheduling, registration, and assistance with determining insurance eligibility. RCM efforts take place during and after clinical care, too, such as reliable charge capture, coding medical procedures for billing, and submitting claims with insurance companies.

Healthcare revenue cycle management programs that can link as many of these steps together have the best prospects of long-term financial health.

A Closer Look at the Patient's Journey



Pre-registration

Upon initial contact with a patient, as much information as possible is gathered about the patient and their insurance to help expedite time-consuming administrative requirements before any clinical service takes place. This is a key component in getting a patient engaged in their own healthcare early in the process. Communication tools can be used to share information with the appropriate doctors, nurses, and administrative staff throughout the care facility to better inform preparations for clinical service.

Registration

This refers to the collection of any outstanding patient information and consent required for the medical record in order to meet established clinical, financial, and regulatory demands. This is an opportunity to further engage patients, alert them to potential financial obligations, and better educate them about next steps in their care experience. A patient registrar can help identify alternative payors such as government entities (e.g., Medicare and Medicaid) or other liable third parties.

Charge Capture

This refers to the process physicians use to record information about the services they provide to be put into a medical claim for billing. Without accurate documentation of clinical care services, revenue could be lost because charges are incorrect or aren't made at all. It's best if a hospital's charge capture system can interface with the Electronic Medical Record (EMR) to optimize identification and capture of charges for more complete billing. Hospitals also should consider centralized charge standards across all departments to improve consistency.

Utilization Review

Analyzing clinical treatment to evaluate whether it is medically necessary as a means of reducing costs and improving patient health outcomes. Patient advocates and case managers will advise patients and review their care to help determine what level of service is appropriate and effective. Utilization review also allows providers to better manage their resources; e.g., helping patients transition from hospitalization to long-term and post-acute care.

Coding

Specially trained staff identify medical diagnoses and procedures and document them in a patient's medical record as universally accepted codes, such as Current Procedural Terminology (CPT) code and International Classification of Diseases (ICD) code. These codes are applied to a patient's record, and insurers use them to evaluate the appropriate amount of payment for a medical bill. Coders should be certified and pursue ongoing training on current practices to ensure coding compliance, consistency, and accuracy.

Third Party Follow-Up

This includes identifying and pursuing third-party payors and collecting payments on behalf of patients. Third party follow-up is important because in most cases you cannot bill Medicaid or Medicare until you've explored other options – federal regulations require that Medicaid and Medicare are payors of last resort. And accident insurance will often pay out much higher than the Centers for Medicare & Medicaid Services (CMS), which is known for reimbursement rates as low at 25%.

Claim Submission

How healthcare providers submit billable fees to eligible payors such as insurance companies. A "clean" claim – one that gets reviewed and paid by a payor upon initial receipt – expedites reimbursement and improves cash flow. Consistent, accurate

coding can reduce errors that eventually result in claim denials and can increase the frequency of clean claims.

Patient Responsibility

When a bill for medical services is not entirely covered by insurance or other payors, patients are responsible for paying the remainder and providers must work with patients to collect. But patients often are confused about what's required of them and what options they have. So, it's essential that providers immediately engage with patients help them understand what they owe, identify primary or secondary insurance, consolidate bills, and set up payment plans.

Remittance Processing

The review of payments associated with a bill for medical services to determine whether to accept or deny such payments. A hospitals' accounts receivable systems should verify insurance, process claims electronically whenever possible, submit clean claims, and appeal (as necessary) in a timely manner to net maximum collections in less time. Specialists also can help patients identify potential financial assistance and navigate the complex billing process.

Commit to the Long Road of the Financial Journey

The financial path can be a long road to travel, but there are ways RCM can make the journey easier.

Optimize Revenue Cycle Service Lines through Integration

Integrating multiple revenue cycle management service lines enables them to work better together throughout the continuum of care. Service line integration can help:

- Reduce the burden on patients by simplifying financial obligations and eliminating unnecessary vendor handoffs.
- Improve the flow of information and coordination of care among different teams within a health system.
- Better maintain compliance across various government programs.
- Reduce costs through faster, more efficient management of clinical and financial operations.

For example, by combining thorough Eligibility screening and Third Party Liability referral and follow-up, hospitals can improve identification of third-party payors and ensure faster, better reimbursement. Download this white paper to learn more»

Or in another case, integrating Eligibility with Patient Responsibility allows for discovery of eligibility programs whenever possible and for a smooth transition to a self-pay program when necessary.

Leverage Revenue Cycle Technology to Increase Efficiency

Modern healthcare technology solutions are an integral part of RCM. The power of today's tech allows health systems to incorporate processes, services, and products into a software platform designed around the patient and capable of streamlining operations throughout the organization.

Patient account representatives can use advanced systems to scan the available programs at all levels across the country to improve screening and eligibility analysis. Powerful technology platforms also have the ability to rescreen in real time and simultaneously scan state and commercial databases for potential coverages on all self-pay patients and any third-party Liability case that doesn't have a secondary payor identified – ensuring another payor is identified if/when an eligibility case is insufficient.

Technology makes it more convenient to glean insights from all patient account transactions – charges, scans, phone calls, letters, verifications – to quickly adapt to trends and to inform the development of new processes. Reporting also is enhanced through simple and secure access to detailed operational, financial, productivity, and clinical data that's gathered.

Expand Patient Engagement Beyond the Bedside Throughout the Revenue Cycle

Patients have more choices than ever when it comes to healthcare. Effective communication and thorough engagement with patients are critical for hospitals and care providers to improve financial and health outcomes. Revenue cycle management has tools and services to make it happen.

Patient engagement technologies such as healthcare-related mobile applications can help bridge gaps in care. Patients engage with their physician and manage their own healthcare with the ease of a few swipes on a cellphone. Patients and providers use

that technology to stay connected through pre-, intra-, and post-operative care and even during long-term recovery.

RCM field advocacy programs also help keep patients engaged once they've left the hospital. Screening and application for assistance aren't always completed before a patient is discharged from the hospital, and patients could lose interest in receiving assistance once they're out. When patients don't receive assistance that's available to them, hospitals could lose revenue. But extended outreach through field advocacy – including home visits – can help patients find resources to pay their bills and enhance reimbursement for hospitals.

To contact an Ascensor Consulting account manager for this or other services, call 1-800-446-6916 or visit www.ascensorconsulting.com/contact to submit a request.