

Revenue Cycle Management -

Billing is a "Team Effort"
or "It Takes A Village"

Reproductive Health Update –
Regional Meeting

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presenter:

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Revenue Cycle Management – Billing is a “Team Effort” or “It Takes a Village”



Since 1981, SHR Associates, Inc. (SHR) has been dedicated to providing physicians, hospitals and health care organizations with the business tools and resources necessary to respond and successfully operate in today's ever-changing health care environment.

2



Health care organizations across the country, both public and private, are feeling the pressure of the many economic and regulatory changes taking place in the industry.

While the ultimate course of national health care reform is uncertain, health care administrators, providers and their organizations are being required to respond to a myriad of fiscal and political challenges.

In addition, the new diagnostic coding system, ICD-10, signals a proliferation of new codes to be learned – approximately 70,000 as compared to today's 14,000 codes.

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Further, despite the expansion of health care coverage through the provision of the Patient Protection and Affordable Care Act, practices are being challenged by increasing patient deductibles and out-of-pocket expenses.

Because the revenue cycle is a care function that your organization needs to be sustainable, it's important to make it a high priority for every member of your health care team.

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 **Outline of Today’s Presentation**

-  Review each component of the Revenue Cycle Management (RCM) process.
-  Show how each component of the process affects the next, as well as the overall success of the RCM process.
-  Discuss what each member of the team can do to help achieve a successful RCM process.
-  Identify how Key Performance Indicators (KPI) can be used for RCM monitoring and process improvement.
-  Identify additional RCM references and resources.

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A **TEAM** is “a group of individuals working together, striving to achieve a common goal that they all believe in and that would be difficult, if not impossible, to achieve by people working alone.”



Michael Maginn. (2004) Making Teams Work – 24 Lessons for Working Together Successfully. New York, NY: McGraw-Hill Professional Education Series.

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To assure successful and compliant billing, everyone in the organization needs to be familiar with each step of the RCM process. **Billing requires a “team effort”.**

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Encounter

An encounter should be created for each patient visit. The flow of the encounter begins at the time of scheduling and flows through the billing and collection process.

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Encounter

The encounter is not complete until the charges have been reconciled by posting the associated payments and/or adjustments.

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The Components of Revenue Cycle Process

Front-end Operations

- Appointment scheduling
- Pre-registration and authorization
- Reminder call
- Registration/check-in
- Eligibility verification
- Visit: Charge capture and coding
- Check-out
- Reconciliation processes

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The Components of Revenue Cycle Process

Back-end Operations

- Claim submission
- Clearinghouse
- Remittance/Payment posting
- Claims follow-up and A/R management
- Patient billing
- Benchmarking/KPI
- Auditing and third party contracting

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Appointment Scheduling

The first step of the encounter involves making the appointment and setting up the account to prepare for billing and patient contact. If the appointment is scheduled incorrectly, the patient may be dissatisfied and revenue may be lost.

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Appointment Scheduling

Electronic systems for appointments greatly facilitate the appointment scheduling process and help to ensure that complete demographic and insurance information is obtained. If possible, assigning staff to collect detailed information from the patient prior to the appointment will greatly facilitate the check-in process.

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Appointment Scheduling

Obtaining contact information in advance allows you to contact the patient to remind them of the appointment, verify information and reschedule an appointment, as necessary.

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Appointment Scheduling

If the appointment scheduling is not done properly, the clinic will not be able to verify coverage, and the patient may not bring the required documents or be prepared to pay for services.

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Pre-registration and Authorization

Using the information collected at the time of scheduling to verify eligibility and obtain authorization for the appointment (or specific services) helps to identify missing or inaccurate information and ensure that services requiring pre-authorization are covered and paid.

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Pre-registration and Authorization

Pre-authorization and eligibility for most payers today can be accomplished online and most state-of-the-art practice management (PM) systems have the capability for automated pre-authorization and eligibility verification.

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Pre-registration and Authorization

If pre-authorization and eligibility are not checked prior to the visit, claims may be denied for missing authorization or required referrals and revenue will be lost.

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Reminder Calls

Contacting the patients to remind them of their upcoming appointment greatly reduces the chances for a no-show and provides an opportunity to discuss payment issues. Most PM systems today have the capability to automate patient reminder and follow-up calls.

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Registration/Check-in

The registration/check-in process provides the opportunity to verify the patient's identity and insurance information and confirm the reason for the visit. Due to the complexities of the various insurance plan requirements and coverage, front office staff need to be well-trained and provided with quick reference materials on all insurance plans in which the organization participates.

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 **Key Steps for Time of Service Registration**

- Complete patient registration forms
- Complete HIPAA forms
- Copy/scan insurance cards and photo ID
- Collect copayment and any outstanding balances

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Eligibility Verification

The information provided at check-in should be used to verify eligibility. Even if this process has been done prior to the visit, this step is important to verify that the coverage is active at the time of service.

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Eligibility Verification

This process also identifies the amount that the patient is obligated to pay for deductibles, co-payments or co-insurance. Arranging for collecting these payments from the patient at check-in greatly improves the ability of the clinic to obtain those funds.

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These “front-end” functions have typically been done by administrative staff who are often some of the least experienced, least paid employees in the organization.

Practices that utilize more experienced Billing staff in these key functions experience cleaner claims, fewer denials and lower accounts receivable.

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Consider partnering Billing staff with Front-Office staff to strengthen these processes or ensure there is good, frequent communication between “front and back.”



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Charge Capture and Coding

All clinical services need to be properly documented, coded and captured as charges for billing. Organizations should utilize an encounter form/superbill/charge ticket in either a paper or electronic format.

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Charge Capture and Coding

Practices using a paper encounter form or superbill often fail to update the document to add new codes or delete obsolete codes. When possible, forms should also include common services mapped to CPT codes.

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Charge Capture and Coding

Management should ensure that providers complete their notes and submit their charges for billing in a timely manner. Failure to submit claims on a timely basis impacts the organization's cash flow and may result in denial of the service.

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Coding and Documentation

- More patients will be eligible for Medicaid and health insurance.
- Self-pay will become a larger percentage of your payer mix.
- Accurate coding and reporting are critical to sustainability.
- The medical record must support the codes reported that payment will be based upon.

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Documentation of Services

The basic principles for documentation of services provided are:

- If it is not documented, **it did not happen.**
- If it cannot be understood, **it did not happen.**
- If it cannot be read, **it did not happen.**
- If it did not happen, **it should not have been paid.**
- If it was paid, **the money should be paid back.**

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Steps To Strengthen Documentation of Services

- Use templated EHR or hard copy formats to document services.
- Determine payer-specific documentation guidelines for rendered services.
- Document timely and thoroughly.
- Documentation must be well-organized.

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Coding: Evaluation and Management Services (E/M)

E/M codes are used for reporting:

- Treatment for STD, HIV, gynecologic and other problem-oriented conditions.
- Family planning and contraceptive management.
- Discussion and counseling education by reportable providers.

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Tips for Successful E/M Coding

- Use the 1995 or 1997 E/M documentation guidelines.
- Train providers and coding staff on E/M criteria.
- Develop strong templates.
- Documentation must support “medical necessity”.
- Use modifier 25 for separately identifiable E/M services.
- Know the “New” vs. “Established” patient rules by payer.

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Coding: Evaluation and Management Services (E/M)

E/M Documentation Components:

- History
- Physical Exam
- Medical Decision-making – (don’t underestimate the acuity of care provided.)
- Time-based Coding (when counseling is the primary service.)

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Steps to strengthen the charge capture process:

- Follow the path of an encounter to identify all billable clinical services provided.
- Shadow providers to identify actual services provided.
- Identify correct and accurate codes for services.
- Ensure that all services are billed correctly (coding and modifier rules).



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Steps to ensure accurate code selection:

- Import codes from EHR, if possible.
- Design/update encounter forms (superbills) for accurate charge capture.
- Connect payable diagnosis codes to procedure codes.
- Ensure the accuracy and validity of codes.
- Audit encounter forms (superbills) and/or imported codes.
- Provide continuing education and feedback to providers for coding accuracy and patterns.

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Charge Reconciliation

- Use visit tracking reports to identify no-shows, missed charges.
- Reconcile posted charges to source documents, e.g., encounter forms (superbills).
- Reconcile encounters to patient sign-in sheets.
- Reconcile service volumes to external resources, e.g., lab logs.
- Reconcile to inventory control for injectables and other billable supplies.
- Post charges within 24-48 hours of service.

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Claims Submission

This is the process of preparing and submitting the claim to a clearinghouse or directly to the payers. All charges and codes should be reviewed to verify that charges are captured and posted correctly. Most PM systems have a “review” feature that identifies errors or omissions on the claims prior to submission (claims scrubbers or edit functions).

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Claims Submission

The organization should have a written procedure for claims submission that includes a schedule for the timing of claims submission (i.e. daily, weekly). This will help to reduce claims denial and/or erroneous billing (i.e. posted to the patient but should go to insurance).

Without a timely and accurate claims submission process, denied claims increase, A/R increases and charges may be missed, resulting in lost revenue.

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Claims Submission

For optimal and accurate claims processing:

- File claims electronically.
- Contract with a reputable clearinghouse.
- Look for high functionality in the PM system.
- Preview claim reports.
- Correct errors prior to submission.
- Reconcile Submission reports to Acceptance reports.

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Clearing House

A clearing house is a private company that provides connectivity between providers, billing entities, health insurers and other health care partners for transmission and translation of claims (primarily electronic). Information is changed into the specific format that the health insurer requires.

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Clearing House

Clearinghouses may contract with or act on behalf of one of a number of health insurers or may contract with medical practices to transmit and/or translate claims information.

Sample Clearinghouses: Emdeon (WebMD), PayerPath, McKesson

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Clearing House

Organizations may submit claims from their practice management system directly to the carrier but they don't get the benefit of additional edits and may need to devote more staff time to correcting denied claims.

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Remittance Advice and Payment Posting

Clean claims will be either be paid, applied to co-insurance or deductibles, or denied. The Remittance Advice (RA) or Explanation of Benefits (EOB) sent from the payer explains how payments or denials were applied.

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Payment Processing/Monitoring

- Enroll in electronic fund transfers (EFT) and electronic remittance advice (ERA).
- Use software to track payment variances from contracted rates.
- Ensure that fees are above contracted rates.
- Train staff to monitor contractual amounts and bundling edits.

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Payment Processing/Monitoring

Timely posting of payments ensures updated balances and correct A/R management. Updated balances provide opportunities to pursue reimbursement from secondary payers or patients, as appropriate.

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Electronic EOB/RAs are obtained by:

1. Going to the insurance carrier's website and printing the EOB/RA
2. Electronic Remittance Advice (ERA) which download into the Practice's medical billing software and is posted electronically to the patient's account.

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Insurance Reimbursement:

Payments are primarily obtained by either:

- Mailed in check
- EFT - electronic funds transfer: electronically sent to the bank
- Credit card voucher mailed to the Practice

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Claims Follow-up and A/R Management

This is the process of tracking claims that have been submitted to ensure that proper payment is received. Appropriate action (resubmission, appeal or write-off) must be taken on claims that are either denied, not paid in full or not responded to by the payer.

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Claims Follow-up and A/R Management

Many denied claims contain easily corrected errors. Those claims should be modified and resubmitted for approval and payment. Correcting and resubmitting claims in a timely manner will reduce “days in A/R” and help to avoid denials due to untimely filing limits.

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Denial Management

- Monitor claim denials to identify trends.
- Analyze reports indicating frequency of “Remark” codes.
- Track denials by payer, type and provider.
- Correct the root problems for the denials and rejections.
- Follow-up on denials within 24 hours.
- Develop appeal letter templates.
- Educate staff on payer-specific policies.

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Denial Management

Most common reasons for denials:

- Demographic errors
- Lack of “medical necessity”
- Lack of pre-authorization
- Delays in timely filing
- Duplication of claims
- Additional information required
- Coding errors



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Denial Management

One additional type of denial is one that practices will be seeing much more of – when all or a portion of the claim is not paid but applied to the patient's deductible or co-insurance. Predictions are that practices will have approximately 40% of their revenue due directly from patients (up from 10% in 2010).

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Denial Management

To help reduce the incidence of denials, staff should have easy access to:

- Administrative payer manuals.
- Program manuals and policies.
- Newsletters and Provider bulletins.
- Web access to fee schedules and claim management.

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Accounts Receivable Management

To strengthen the Accounts Receivable Management process:

- Implement written procedures for tracking and working outstanding insurance claims.
- Build relationships with third party Provider Representatives for outreach and education.
- Implement a written Financial policy, including guidelines for payment plans and monitoring.

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Patient Billing

Patients may need to be billed after their insurance has responded and/or if they are uninsured or do not wish to bill their insurance. It is very important to ensure compliance with payer requirements before billing patients.

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Patient Billing

Statements should be generated on a regular basis (weekly, 2-3 times/month). With many PM systems today, patient statements can be generated electronically which can be very cost-effective and allows the clinic to use their internal staff for other tasks.

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Patient Billing

There should be clear, written policies and procedures for the patient billing and collection process, including when balances should be billed to patients and how many statement should be sent.

Statements should not “threaten” collection unless the organization intends to send delinquent accounts to a collection agency.

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Benchmarking and KPI

Establishing benchmarks and tracking key performance indicators helps the organization establish goals, monitor performance and make improvements. If you don't monitor your revenue cycle management process, you don't know where you stand or if your RCM processes are effective.

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 **KEY PERFORMANCE INDICATOR (KPI)**

A standard set of monthly management reports should be identified and consistently run at each month-end.

The monthly results should be reported and compared to prior months and year-to-date. They should also be compared to benchmarks and goals set by the organization, as appropriate.

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KPI Reporting

Every organization needs to develop a Key Indicator dashboard to monitor the financial health of your revenue cycle. Regularly monitor key statistics should include:

- Charges and payments
- Days in Accounts Receivable
- A/R Aging - Current, 31-60 days, 61-90 days, 91-120, Over 120
- Collection ratios and aging by payer
- Denials
- New and established visit volumes

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The Auditing Process

- Implement a Billing Compliance Plan and perform internal audits on a regular basis.
- Perform retrospective audits to identify areas of weakness and take corrective action.
- Retain an independent consultant to help establish the baseline audit process.
- Implement educational tools and ongoing training for providers and staff.

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Sample Audit Tool



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Third Party Contracting

This may be the most critical step in the revenue cycle process.

In considering the contract process:

- Identify the health plans in your area.
- Project the number of covered members.
- Determine your capacity to serve additional patients.

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Considerations for Third Party Contracting

- Do the proposed fees cover your costs?
- Are timely filing and appeal limits acceptable?
- What is the payment cycle, e.g., 14 days?
- Does the payer provide electronic remittances (ERA)?
- What percentage of services require pre-authorization and/or written referral?
- What is the payer’s methodology for recoupment and what is the time limit?

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Additional Considerations for Third Party Contracting

- Will the payer provide their denial methodology?
- What are your appeal rights and do they comply with state and federal law?
- Does the plan credential midlevel providers?
- Credentialing and recredentialing terms and procedures – Do they use the CAQH universal provider database ?
<https://upd.caqh.org/oas/>

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Third Party Contract Negotiations

To help negotiate better contract terms and reimbursement:

- Demonstrate high quality of care.
- Demonstrate compliance with AMA and EBM guidelines.
- Collect data on after hours services vs. ED care, e.g., service utilization .
- Prepare a cost analysis or comparison.

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Summary of Best Practices for monitoring your RCM process:

- Hold monthly Revenue Cycle Management team meetings.
- Track and monitor key performance indicators (KPI).
- Benchmark against industry standards and internally to trends over time.
- Use a dashboard to manage and measure revenue cycle improvement and goals.

Ongoing monitoring of these key metrics is essential to improved revenue cycle performance. With the right tools and information, your organization can experience fewer denials, faster payment and greater profitability.

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In summary, each component of the RCM process must continually be monitored to ensure that value is delivered and that revenue is maximized.

One of the most important steps you can take is to help create an environment of understanding that everyone in the organization is responsible for revenue. When everyone recognizes and appreciates the role that they play, revenue will improve.

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The revenue cycle of health care organizations comprises many functions that draw on the performance of a wide range of individuals – administrative staff, clinical staff and management. Considering the many challenges your organization will face in the coming years, investing and improving your revenue cycle performance will be one of the wisest investments you can make!

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- AMA Glossary of terms
- AMA - How to select a practice management system
- RCM Action Plan

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Ms. Nancy Smit is President/CEO and founder of SHR Associates, Inc. (SHR). She is directly responsible for all aspects of the firm's consulting and practice management activities, from reviewing and analyzing the internal operations of physician group practices and hospital-affiliated programs, through the design and implementation of strategic plans, networking arrangements, and practice enhancement programs for SHR's broad range of health care clients. Ms. Smit has served in the capacity of Executive Director for several large multi-specialty academic practice plans formed and managed by SHR, as well as provided oversight and direction for the implementation and operation of numerous hospital/physician joint ventures and limited liability corporations. More recently, she has led the firm into multiple projects with community-based clinics, health departments and FQHCs, helping organizations with limited resources adopt and implement more efficient and compliant processes to improve their access to care and ability to obtain third party payment for their newly insured patients under health care reform.

Ms. Smit received her undergraduate degree in physical therapy from the University of Connecticut, her respiratory therapy degree from University of Chicago Hospitals and Clinics, and her master's degree in Business Administration (MBA) from Loyola College, Baltimore, Maryland.

Glossary of Terms

The following is a list of frequently used billing and insurance terms as defined by Centers for Medicare and Medicaid Services (CMS).

Advance Beneficiary Notice (ABN): A notice that a provider or facility should give a plan beneficiary to sign in the following cases: Your doctor gives you a service that he or she believes that the plan may not consider medically necessary; and your doctor gives you a service that they believe the plan will not pay for. The ABN may also be referred to as a waiver.

Allowed Charge: Contracted rate for individual charges determined by a carrier for a covered medical service or supply

Appeal Process: The process you use if you disagree with any decision about the health care process, service or payment. If the participant is in a managed care plan, they can file an appeal if the plan will not pay for, or does not allow or stops a service that the patient or provider believes should be covered or provided. The plan may have special protocols to follow in order to file an appeal. See the plan's membership materials or contact the plan for details about appeal rights and procedures.

Approved Amount: The negotiated amount established in the agreement between the provider and plan to cover a particular service

Assignment: A process whereby a plan or payor, pays its share of the allowed charge directly to the physician or supplier.

Balance Bill: Billing a member for the difference between the allowed charge and the actual charge.

Beneficiary: The person who is eligible to receive benefits through a health insurance program.

Benefits: The money or services provided and covered under an insurance policy.

Carrier: An entity that may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan

Cash Basis: The actual charge of the service when the service was performed

Centers for Medicare and Medicaid Services (CMS): The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Claim: A claim is a request for payment for services and benefits received. Information is customarily submitted by a provider to establish that medical services were provided to a covered person.

CMS-1500: The uniform professional claim form.

Coinsurance: The co-payment a member makes based on a percentage of the costs of the medical services received, usually around 10 to 20 percent. Coinsurance is usually found in indemnity, fee-for-service and PPO plans, often along with deductibles.

Confidentiality: The ability to speak with the provider or representative without disclosing the information to an uninterested party.

Coordination of Benefits (COB): A process that applies when determining which plan or insurance policy will pay first if multiple policies exist.

Copayment (co-pay): The set amount, usually \$5 to \$25, an HMO member pays the provider for services. Unlike coinsurance, this amount is not based on a percentage of the actual cost of services, but is pre-determined.

Covered Services: A health service or item that is included in the benefit plan, and that is paid for either partially or fully.

Covered Entity: Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction

Deductible: The dollar amount that a member must pay for medical services before health plan coverage begins.

Demographic Data: Data that describe the characteristics of the beneficiary and/or guarantor. Demographic data include but are not limited to age, sex, race/ethnicity, and primary language.

Department of Health and Human Services (DHHS): DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. It is the "parent" of CMS.

Determination: A decision made to either pay in full, pay in part, or deny a claim.

Diagnosis Code: ICD-9-CM diagnosis code sets that correspond to conditions that (co)existed at the time of treatment.

Disclosure: Release or divulgence of information by an entity to persons or organizations outside of that entity.

Dis-enroll: Ending health care coverage with a health plan.

Effective Date: The date on which health plan coverage begins.

Eligibility: Refers to the process whereby an individual is determined to be eligible for health care coverage through their plan.

Eligibility Date: The date on which health plan coverage begins.

Enroll: To join a health plan.

Explanation of Benefits (EOB): A coverage statement that is sent to the patient and/or provider when a claim is filed. The EOB shows what the provider billed for, the plan's approved amount and how much they paid.

Fee Schedule: A list of services and their respective charge

Fee-for-Service: A method of paying the provider for service or treatment based on the fee schedule.

Guarantor: The person responsible for payment of rendered services. The guarantor is customarily the person bringing the patient in for treatment. This person is not necessarily the same as the subscriber.

Health Care Provider: A person who is trained and licensed to give health care.

Health Insurance Portability and Accountability Act (HIPAA): HIPAA is the Health Insurance Portability and Accountability Act signed into law in 1996. An Administrative Simplification section in the law requires adoption of standards for security, privacy and electronic healthcare transactions.

Health Maintenance Organization (HMO): A legal corporation that provides health care in return for pre-set monthly payments. For most HMOs, members must use the physicians, hospitals and other health care professionals in the HMO's network in order to be covered for their care. There are several models of HMO, including the Staff Model, Group Model, IPA Model, Direct Contract Model and Mixed Model.

Health Plan: An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.

Indemnity: This is a form of coverage offered by most traditional insurers.

Managed Care: An HMO, PPOs and some forms of indemnity insurance coverage that incorporate preadmission certification and other utilization controls

Managed Care Organization (MCO): A health plan that provides coordinated health care through a network of primary care physicians and hospitals for pre-set monthly payments

Medicaid: Medical Assistance is a joint federal and state program to cover medical costs for qualifying low-income individual. Medicaid programs vary from state to state

Medicaid MCO: A Medicaid MCO provides comprehensive services to Medicaid beneficiaries. Maryland has seven (7) MCO's, Amerigroup, Maryland Physicians Care, Priority Partners, Riverside Health, United Health Care Community Plan, MedStar, and Jai.

Medically Necessary: Services or supplies that: are proper and needed for the diagnosis, or treatment of your medical condition; are provided for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or provider.

Medigap Policy: A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage.

Member: See Subscriber.

Network: A group of health care providers and suppliers of other goods and services to provide service to patients.

Non-covered Service: The service (a) does not meet the requirements of a benefit and (b) may not be considered reasonable and necessary.

Non-participating Physician: A provider that is not contracted or accepts assignment with a particular plan.

Nurse Practitioner: A nurse who has advanced training and assists physicians by providing care to patients in their absence. NPs are considered providers.

Out of Network: Services a member receives from a health care provider who does not belong to the member's health plan's network of selected and approved physicians and hospitals

Out of Pocket Costs: Health care expenses that the patient is responsible for as they are not fully or partially covered by their plan.

Participating Physician or Supplier: A provider who agrees to accept assignment on the claims. These providers should only initially bill for the patient's cost share amount.

Payer: Insurance company

PCP - Primary Care Physician (PCP): A physician, who usually specializes in family practice, general practice, internal medicine or pediatrics, who provides or coordinates patient care.

PMS: Practice Management System: The software or system the provider uses for billing.

Point of Service (POS): A health plan option that allows members to use either a network provider or a non-network provider at their discretion. If a member chooses to go out of network, they may pay a higher co-pay or deductible.

Preferred physicians and/or health care practitioners (providers): The term used to describe the physicians, health care practitioners and facilities included in an insurance plan network.

Preferred Provider Organization (PPO): A network of doctors and hospitals that provide health care services at a pre-negotiated lower price. Members receive better benefits when they use network providers, but have the option to use out-of-network providers for higher out-of-pocket costs.

Premium: The predetermined monthly membership fee a subscriber or employer pays for health plan coverage.

Preventive Care: Care designated to keep the patient healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.

Primary Care: A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.

Primary Payer: An insurance policy, plan, or program that pays first on a claim for medical care.

Protected Health Information (PHI): Individually identifiable health information transmitted or maintained in any form or medium, which is held by a covered entity or its business associate. Identifies the individual or offers a reasonable basis for identification. Is created or received by a covered entity or an employer. Relates to a past, present, or future physical or mental condition, provision of health care or payment for health care

Provider: Any healthcare provider such as hospital, physician, non-physician provider, laboratory, etc. that provides medical services.

Referral: The formal process that gives a health plan member authorization to receive care from a provider other than his or her primary care provider. Without a referral, such care may not be covered.

Secondary Payer: An insurance policy that supplements the primary coverage and pays second on a claim for medical care.

Self-Insurance: Practice of an individual, group of individuals, employer or organization that assumes complete responsibility for losses, which might be insured against, such as health care expenses. In effect,

"self-insured" groups have no real insurance against potential losses and instead maintain a fund out of which is paid the contingent liability subject to self-insurance.

Self-Pay: A term to mean that the patient owes the medical bill.

Statement: A bill that is sent to the patient for services/items provided.

Subscriber: An eligible employee or eligible retiree who, through his or her place of employment, has enrolled in a health plan.

Superbill (also referred to as; charge document, fee slip; routing slip; encounter form): An internal document created and used to capture medical charges. The superbill typically contains the most frequently used CPT and ICD codes, patient demographic and insurance information.

Termination Date: The date that an agreement expires; or, the date that a subscriber and/or member ceases to be eligible.

Third Party Administrator (TPA): An organization that administers health care benefits-including claims review, claims processing, etc.-usually for self-insured employers.

Timely Filing: Period of time that the provider has to file a claim. This may vary by insurance carrier. Typically the filing period is 6 to 12 months.

Transaction: The exchange of information between two parties to carry out financial or administrative activity.

Revenue Cycle Management - Standard Reporting

| ID | Detailed Activities | Purpose |
|---|--|---|
| Recommended Daily Reports | | |
| 1.00 | Charge Reconciliation Report | Provides information on posted charges to verify and reconcile the charges to every patient seen in the clinic(s). The report should also be reconciled to the service document to verify there are no missed charge posting. |
| 1.10 | Missed Billing Report | Identifies missed charges if the patient was checked in. |
| 1.20 | Front Office Payment Reconciliation Report | Provides the ability to reconcile the cash, checks and credit cards to payments posted in the Practice Management System (PM system). |
| 1.30 | Billing Office Payment Reconciliation Report | Identifies payments posted in the system from the EOBs, ERAs, EFT and mailed payments. This information is reconciled to the bank statement. |
| 1.40 | Missed Appointment Report | Identifies patients that did not keep their appointment so the staff can follow-up or charge a no-show fee. |
| Recommended Monthly Reports | | |
| 2.00 | Aging Summary Report | Provides a snap-shot of the aging of the outstanding insurance and patient balances. |
| 2.10 | Insurance Aging Report | Provides aging information and identifies the payer. Enables the staff to identify which payers have high overdue balances. |
| 2.20 | Insurance Accounts Receivable Report | Provides detail about the overdue insurance balances. Enables the staff to identify patterns and issues so they can work the outstanding insurance balances. |
| 2.30 | Patient Aging Report | Provides aging information on patient balances - current, 30, 60, 90 days and over. |
| 2.40 | Patient Accounts Receivable Report | Provides detail about the patient overdue balance so the staff can work the outstanding patient accounts and/or identify accounts for collections. |
| 2.50 | Payer Denial Reports | Identifies payer denial patterns and assists in identifying inappropriate payer denials |
| 2.60 | Service Analysis Report/Procedure Analysis Report | Provides data on individual CPT codes performed, total amounts charged, paid and adjusted for a specified period. |
| 2.70 | Charge/Payment/Adjustment Report | Provides data on the total charges, payments and adjustments for a specified period. Typically the data is provided by month and by year-to-date. |
| 2.80 | Adjustment Report | Identifies adjusted charges and will assist in identifying adjustment errors. |
| 2.90 | Credit balance report | Identifies refunds that are due to the payer or patient. Each account should be reviewed for posting accuracy prior to a refund being issued. If a refund is issued, accounting must report that information to billing so the refund can be posted against the credit balance. |
| 2.10 | Patient Collections Report | Identifies delinquent accounts and assists in process management. |
| Recommended Tracking and Monitoring Logs | | |
| 3.00 | Create and monitor claims sent, denied and received. | SHR created a Electronic Claims Tracking Log to assist the Practice in tracking when, if and how many electronic claims were filed and received. The log also allows the user to track that Clearinghouse and Payer denials have been reviewed and worked. |
| 3.10 | Create and reconcile ERA's with EFT (log). | SHR created a ERA/EFT Reconciliation Log to identify missing ERA, EOBs or electronic payments. |

Revenue Cycle Management - Standard Reporting

| ID | Detailed Activities | Purpose |
|---|--|--|
| 3.20 | Patient Statement Tracking Log | SHR created a Patient Statement Tracking Log to assist the Practice in tracking when and how many patient statements were sent. This will assist the Practice in monitor the number of stamps, envelopes, paper, etc. SHR recommends processing patient statements electronically. Electronic statements reduce costs and improve staff efficiency. Clearinghouse offers this service. PM system must be able to submit an electronic file to clearinghouse. |
| Recommended Staff Meetings and Regular Communication | | |
| 4.00 | Schedule regular billing office staff meetings to review and discuss billing changes and issues. | |
| 4.10 | Schedule regular provider meetings or develop an internal method to communicate with providers regarding coding and billing issues that specifically relate to the them. | |
| 4.20 | Schedule regular front office staff meetings to review and discuss billing changes and issues. | |
| 4.30 | Schedule regular/periodic staff meetings to discuss and update the entire Clinic team about billing issues and how to improve RCM. | |