Case Study: Revenue Cycle Redesign

Objectives

➢ Provide an overview of the revenue cycle
➢ Describe common revenue cycle obstacles encountered in daily operations
➢ Discuss department specific revenue cycle issues and strategies for how to overcome

Revenue Cycle Redesign

Revenue Cycle Overview
Revenue Cycle Overview

What is the revenue cycle?

The Healthcare Financial Management Association (HFMA) defines revenue cycle as "All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue."

Revenue Cycle Overview

➢ Intake
➢ Insurance Verification
➢ Authorization
➢ Scheduling
➢ Patient Management
➢ OASIS Completion
➢ Document Management
➢ Supply/Drug/DME
➢ Billing and Collections
➢ Reporting

Revenue Cycle Overview

How does the revenue cycle work?
Revenue Cycle Overview
Questions to ask when evaluating revenue cycle functions

What? What is the task?
Who? Who is responsible for completing?
Where? Where is it completed?
When? When does the task get completed?
Why? Why is the task being completed?
How? How does it get completed?
How Many? How many people are needed?

Revenue Cycle Redesign
Common Obstacles

1. Staffing
Common Obstacles

2. Structure

Common Obstacles

3. Duplication

Common Obstacles

4. Technology
Common Obstacles

5. Communication

Common Obstacles

6. Productivity

Common Obstacles

7. Accountability
Common Obstacles

8. Paper!!

Common Obstacles

9. Management

Revenue Cycle Redesign

Specific Issues and Solutions
Specific Issues and Solutions

Intake

➢ Issues
  ➢ Low Conversion Percentage
  ➢ Incomplete/Incorrect Documentation
  ➢ Delayed Admissions
  ➢ Low Productivity

➢ Solutions
  ➢ Intake and Marketing collaboration
  ➢ Easy access to Referral Log
  ➢ Flex and extend Intake hours for coverage
  ➢ Blended staffing model (clinical and clerical)
  ➢ Track productivity

<table>
<thead>
<tr>
<th>Staff</th>
<th>Referral/Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>8-10</td>
</tr>
<tr>
<td>Clerical</td>
<td>15-20</td>
</tr>
</tbody>
</table>

Specific Issues and Solutions

Insurance Verification

➢ Issues
  ➢ Denials for incorrect insurance
  ➢ Denials for no authorization
  ➢ High patient pay A/R

➢ Solutions
  ➢ Designated staff for insurance verification
  ➢ Educate staff on which payors your agency accepts
  ➢ Access payor portals
  ➢ Determine patient co-pays and deductibles up front
  ➢ Standardize documentation in EMR for verification
  ➢ Increase verification frequency
  ➢ Automate re-verification

<table>
<thead>
<tr>
<th>Payor</th>
<th>Initial</th>
<th>On-going</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>100%</td>
<td>Batch</td>
</tr>
<tr>
<td>Non-Medicare</td>
<td>20/Day</td>
<td>Batch</td>
</tr>
</tbody>
</table>

Specific Issues and Solutions

Authorization

➢ Issues
  ➢ Denials for lack of authorization
  ➢ Backlog in authorization requests
  ➢ Delays in start of care

➢ Solutions
  ➢ Designated staff for authorization
  ➢ Access payor portals
  ➢ Standardize documentation in EMR for authorization
  ➢ Proactively identify expiring authorizations reports
  ➢ Communicate with clinicians in advance of expiring authorizations
  ➢ Hold clinicians accountable for visits made without authorization

<table>
<thead>
<tr>
<th>Payor</th>
<th>Initial</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medicare</td>
<td>15-20/Day</td>
<td>100-150 FTE</td>
</tr>
</tbody>
</table>
Specific Issues and Solutions

Scheduling

**Issues**
- High number of missed visits
- High SOC to evaluation lag time
- High staff overtime

**Solutions**
- Systematic approach to utilizing EMR for scheduling
- Approve frequency of visits
- Utilize “Pending” report to prioritize SOC
- Schedule SOC visit within 24-48 hours
- Centralize?
- Self schedule?

Census
200-300/FTE

---

Specific Issues and Solutions

Patient Management

**Issues**
- High LUPA %
- Under/over visit utilization
- Inconsistent recertification percentage

**Solutions**
- Episode Management
- Weekly case conferencing
- LUPA Management
  - Analyze LUPAs – retrospective and proactive
  - Unavoidable vs. Avoidable
  - Staff Education
- Establish process for recerts (reports, timing, etc)
- Trend your data
- National LUPA rate: 10.1%*
- Average Visits/Episode: 17.28*

*source: Strategic Healthcare Programs

---

Specific Issues and Solutions

OASIS Completion

**Issues**
- High days to RAP
- Low case mix

**Solutions**
- Finance and Clinical Collaboration
- Weekly Revenue Cycle meeting
- Five Day Rule - OASIS, 485, SOC visit, recert visit
- Accountability for clinician response time to QA
- QA staff have both coding and OASIS certification
- Publish case mix weight by clinician
- Monthly scorecard review
- Implement performance improvement plan (PIP)
- Trend key indicators

<table>
<thead>
<tr>
<th>Days to RAP</th>
<th>Case Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-7</td>
<td>1.069</td>
</tr>
</tbody>
</table>

*source: Strategic Healthcare Programs
Specific Issues and Solutions

Documentation Management

Issues
➢ High number of unsigned orders/P2F
➢ Increased unbilled A/R

Solutions
➢ Obtain as much information at intake as possible
➢ Establish follow-up protocols
1. Fax order
2. Place phone call 7 days after initial submission
3. Place second call 14 days after initial submission
4. Place third call 21 days after initial submission
5. Utilize liaisons to help retrieve after 28 days
➢ Follow-up by physician rather than patient
➢ Establish incentives for teams
➢ Utilize electronic physician signature portal

Specific Issues and Solutions

Supply/Drug/DME Management

Issues
➢ High supply/drug/DME costs
➢ Timely access of needed supplies, drugs, DME for patients

Solutions
➢ Know your cost per patient per day
➢ Drop ship supplies
➢ Review formulary on regular basis
➢ Engage Pharmacy Benefit Management company
➢ Engage DME Benefit Management company

Specific Issues and Solutions

Billing and Collections

Issues
➢ High Accounts Receivable
➢ Low collectability
➢ Inconsistent cash flow

Solutions
➢ Bill RAPs daily
➢ Electronically submit claims and receive remits through clearinghouse
➢ Collaborate with clinical on any pre-bill errors
➢ Follow-up monthly on all outstanding A/R aged over 60 days
➢ Bill in monthly increments
➢ Trend denials by reason for more insight into revenue cycle issues
➢ Set productivity and cash goals for staff
Specific Issues and Solutions

**Reporting**

- **Issues**
  - Not enough reporting
  - Too much reporting
  - Not looking at the right data
  - Time consuming reporting process

- **Solutions**
  - Develop dashboards
  - Determine source of information
  - If not able to get information from EMR, invest in ancillary software
  - Present data differently for appropriate audience
  - High level for executive team
  - Drill down for management team
  - Acquire, Analyze, Act

Revenue Cycle Redesign

**Case Study: MaineHealth**

Overview - MaineHealth

- $18 Million Annual Revenue
- Home Health, Pediatric and Palliative Care Services
- Services in three counties
- 950 Patient Census
- Payor Mix
  - 71% Medicare
  - 15% Private Insurance
  - 7% Medicaid
  - 7% Other
- Union and non-union staff
Accomplishments
Success Achieved
➢ $1.6 million improvement of bottom line from FY13 to FY14
➢ Revenues improved by $1.2M and operating expenses decreased by $400,000

Revenue Cycle Redesign
Obstacles & Redesigned Process

Intake
Obstacles
➢ F2F physician verification
   ➢ The correct physician signing the F2F was not confirmed at the time of receiving a referral
➢ Referral productivity
   ➢ Number of referrals entered per staff member was not being tracked
Intake

Obstacles

➢ Staffing model
  ➢ Department comprised solely of nurses

➢ Refused referrals not being tracked
  ➢ “Lack of staff for visit”, “Unsafe conditions for clinicians”, etc. not being tracked by Intake

Intake

Redesigned Process

➢ Implemented F2F physician follow-up calls
  ➢ Clerical staff members assigned the responsibility of following up with referral sources to confirm correct physician signing F2F

➢ Utilized EMR report to track referral entry productivity per employee

Intake

Redesigned Process

➢ Introduced staffing model to utilize clerical staff members in place of clinical staff
  ➢ Blended model

<table>
<thead>
<tr>
<th>Current Staffing Model</th>
<th>Previous Staffing Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Clinicians</td>
<td>6 Clinicians</td>
</tr>
<tr>
<td>2 Full Time RNs</td>
<td>1 Weekend RN</td>
</tr>
<tr>
<td>1 Manager RN</td>
<td>1 Part Time RN</td>
</tr>
<tr>
<td>1 Clerical Staff</td>
<td>1 Manager RN</td>
</tr>
<tr>
<td>All entering referrals</td>
<td>1 Clerical Staff</td>
</tr>
<tr>
<td>Intake Assistant</td>
<td>Intake Assistant</td>
</tr>
<tr>
<td>Not entering referrals</td>
<td>Not entering referrals</td>
</tr>
</tbody>
</table>
Intake
Redesigned Process
➢ Developed spreadsheet to track all referrals that were refused before they were entered into the EMR
➢ Allows department to track trends and number of referrals being refused

Insurance Verification/Authorization
Obstacles
➢ Lack of cross training
   ➢ Other clerical back office staff had no training on Insurance Verification/Authorization procedures
➢ Paper-intensive process for requesting authorization
   ➢ Requesting authorization required faxing multiple pages; Portals were not utilized to fullest extent possible

Insurance Verification/Authorization
Redesigned Process
➢ Provided training to other clerical staff members in the back office
   ➢ Created in depth training manuals for their reference in the future
➢ Increased payor portal utilization for insurance verification and authorization requests
   ➢ 75% of all non-Medicare payors completed electronically
Orders Tracking Management

Obstacles

➢ Physician office follow up lag time
➢ Refaxing instead of making follow-up phone calls
➢ No guideline set on when to follow-up on orders with phone call

➢ Management tracking tools
➢ Multiple manual processes utilized to manage department

➢ Outdated Physician Contact Information
➢ Physician information not updated on a regular basis

Redesigned Process

➢ Implemented Forcura
➢ Document management system specializing in the tracking and organization of orders for home health care providers
➢ Assisted in developing a process for follow-up activity as well as managing productivity
➢ Employees required to place a minimum of 30 phone calls per day

Set follow-up expectations

➢ Timeline for orders
1. Fax order
2. Place phone call 7 days after initial submission
3. Place second phone call 14 days after initial submission
4. Place tertiary phone call 21 days after initial submission
5. Utilize liaisons to help retrieve order after 28+ days
Orders Tracking Management
Redesigned Process

➢ Reduced total outstanding orders from 1,319 to 970 in four weeks
  ➢ Total reduction of 26.4%
  ➢ Estimated cash flow impact: $717,600

Scheduling
Obstacles

➢ Department scheduling visits in Excel rather than EMR
  ➢ Results in a manual and complex process

➢ Clinicians not utilizing EMR to post schedules/availability
  ➢ Utilizing the scheduling feature would allow all users to see a clinician's schedule

➢ Clinicians not effectively communicating visits that need to be covered
  ➢ Requires Scheduling department to find coverage

➢ Department regularly works overtime

➢ Intake not effectively communicating pending referrals that require same/next day visits
Scheduling
Redesigned Process
➢ Require all staff to utilize the EMR’s scheduling software
➢ Clinicians post schedules to EMR
➢ Schedulers assign visits through EMR
➢ Hold clinicians responsible for communicating visits that need to be covered in a timely manner

Scheduling
Redesigned Process
➢ Stagger department hours to reduce the amount of overtime
➢ Created pending referral report to prioritize admissions needing same day or next day visit

Clinical Management
Obstacles
➢ Clinicians were not assigned a geographic region to cover
➢ Case Managers were reluctant to perform SOCs, ROCs and Recerts
➢ These are being performed by per diem nurses, resulting in a lack of continuity of care
Clinical Management

Obstacles

➢ Inconsistent communication and responsiveness from clinicians
   ➢ Emails or messages through EMR were not responded in a timely manner
   ➢ Many clinicians struggled with completing the OASIS submission process correctly and timely

Redesigned Process

➢ Assigned clinicians to a specific geographic area
   ➢ Reduces mileage and clinical travel time
   ➢ Promotes continuity of care
   ➢ Communicated clear expectations for clinicians to respond to all agency communication in a timely manner
   ➢ Strengthened OASIS training program to better prepare clinicians

Quality Assurance

Obstacles

➢ Too much responsibility for Quality Assurance (QA) Department
   ➢ Responsibilities included staff education, EMR education, OASIS and Coding reviews, and multiple meetings
   ➢ Three week backlog in OASIS and Coding reviews
   ➢ Unnecessary pre-coding of all referrals
   ➢ 20% of referrals weren’t admitted
Quality Assurance
Redesigned Process
➢ Outsourced backlog of OASIS and Coding Reviews
➢ Eliminated pre-coding of referrals
➢ Reassigned responsibilities of QA department staff

Accomplishments
Success Achieved
➢ Operational Improvements

<table>
<thead>
<tr>
<th>Quarter</th>
<th>0-5 Therapy</th>
<th>% to Total</th>
<th>LUPA</th>
<th>% to Total</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 14</td>
<td>585</td>
<td>58%</td>
<td>15%</td>
<td>17%</td>
<td>1,067</td>
</tr>
<tr>
<td>Q4 14</td>
<td>482</td>
<td>53%</td>
<td>8%</td>
<td>10%</td>
<td>902</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quarter</th>
<th>0-5 Therapy</th>
<th>% to Total</th>
<th>LUPA</th>
<th>% to Total</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 14</td>
<td>620</td>
<td>63%</td>
<td>21%</td>
<td>19%</td>
<td>1,067</td>
</tr>
<tr>
<td>Q4 14</td>
<td>568</td>
<td>59%</td>
<td>19%</td>
<td>18%</td>
<td>902</td>
</tr>
</tbody>
</table>
Questions?

➢ Mike Freytag
  ➢ MikeFreytag@BlackTreeHealthcare.com
  ➢ 610-536-6005 ext 702

➢ Donna DeBlois
  ➢ ddeblois@mhcah.org
  ➢ 207-284-4566

➢ Dave Saling
  ➢ DaveSaling@BlackTreeHealthcare.com
  ➢ 610-536-6005 ext 716