MANAGING THE HOME HEALTH REVENUE CYCLE

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Your Speaker

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The Elements of the Revenue Cycle
The Revenue Cycle

- Intake
- Verification of benefits
- Scheduling of visits
- Authorization of services
- Admission
- OASIS
- Development of the plan of care
- Physician's orders
- Order tracking
- Clinical treatment and documentation
- RAP
- Supply tracking
- Final claim
- Cash posting
- Collections
- Denials and appeals

Internal vs. External

- An internal revenue cycle review
  - You already know how it works
  - You read between the lines
  - You may not know all of the regulations
  - The halo effect
- An external revenue cycle review
  - Consultant knows the regulations
  - Consultant doesn’t know your process
  - Consultant is objective

Revenue Cycle Review Process

- Find out who is supposed to be doing what
- Find out who is doing what
- Find out what nobody is doing
- Compare how things are being done to
  - Best practices
  - Industry standards
  - Regulatory requirements
- Make recommendations for improvement
Job Descriptions

• Begin with job descriptions
  – Be sure they are up to date
  – Be sure staff have a copy of their job description
• Without using the job description, have staff list the following with the required deadlines/timelines
  – Daily duties
  – Weekly duties
  – Monthly duties
  – Other recurring duties

Employee Perception

• Compare employee’s perception of duties with job description to identify disconnects
• Pay particular attention to tasks that are handoffs
  – Look at the flow in both directions
  – Are both employees involved in the handoff able to articulate their role
  – Handoffs between administrative and clinical personnel are particularly vulnerable

Identify Problem Areas

• Clinical start of care
• Documentation from initial visit
• OASIS submission
• Development and review of care plan
• Submission of RAP
• Medical supply usage
• Submission of final claim
• Cash posting
• Payment variances
Interviews

• How to build a paper airplane
  – Have staff describe the duties they listed
  – Have staff demonstrate the duties they listed
  – Identify variances from the job description
    • Have staff explain variances

Purpose of Interviews

• Identify how work is actually being done/not done
• Don’t preach or correct at this stage – information gathering only
• Identify disconnects in process
• Identify errors in procedures
• Identify barriers to quick, efficient claims processing and collection

Referrals

• Source and accuracy of information
  – Electronic
  – Fax
  – Phone
• Completeness
  – How much history is provided?
  – How much data from the hospital/doctor?
  – How accurate is the demographic data?
Referrals

- If you don’t have an electronic documentation system
  - How does information get to the clinician?
    - Fax
    - Phone
    - Hard copy pick up
- How are assignments made?
  - Dialing for clinicians
  - Assigned by area
- How quickly are assignments made?
  - Referral source notification or guarantee of coverage

Verification of Benefits

- Medicare regulations require that beneficiaries be informed of their financial responsibility prior to the initiation of care
- You need to know the payer and their requirements before care is begun so you can capture data correctly
- You need to confirm the payer so that you can get paid
- Medicare requires that you identify if Medicare is the secondary payer
  - MSP questionnaire
- Verify timeliness and accuracy

Verification of Benefits

- Who verifies benefits?
- How do they verify benefits?
- What benefits do they verify?
- When do they verify benefits?
- How do they communicate the benefits with the patient?
- Is there any communication with the clinical staff regarding limitation on coverage?
Visit Scheduling

- Policies
  - Setting schedule expectations
    - Approximate times – not guarantees
  - Expectation of homebound
  - Initial visit
    - Assessment or admission
  - Subsequent visits
    - Cancelled visits
    - Travel only visits

Visit Scheduling

- Who does initial scheduling?
  - Administrative staff
  - Clinical staff
- When are visits entered?
  - MD orders, Authorizations, POC
- Scheduling system
  - Electronic – who enters
  - Manual – who maintains
- Subsequent visit schedule
  - How communicated
- Schedule changes
  - How communicated

Authorizations

- Authorizations affect financial performance
  - Know when authorizations are required
  - Know when authorizations expire
  - Be sure that someone is obtaining authorizations
  - Be sure that someone is supervising that person
  - Be sure that the clinical staff know what visits are authorized
- Are staff held accountable when visits are provided outside the scope of the authorization?
Admissions

• The paperwork black hole
  – What is in your admission packet?
  – How does the packet flow through the agency?
    • Electronic elements
    • Paper documents
  – Does everyone know what to do with the documents?
    • Does someone check the MSP questionnaire?
    • Does someone check for missing clerical documentation?

Electronic elements

OASIS

• Method for completion of OASIS
  – Electronic
  – Paper
    • Manual input
    • Scanning
  – Review of OASIS and comparison with POC
    – Timeliness affects payment
    – Thoroughness affects payment

Development of the Plan of Care

• Time frame
  – Affects timeliness of the RAP
• Process
  – Completed by clinician that performed admission
  – Based on the OASIS assessment
  – Reviewed by supervisor
  – Sent back to clinician for corrections
    • Corrected by supervisor – communicate changes
    – Processed
    – Sent to physician
    – Signed and returned
Physician’s Orders

• Establish relationship with each physician’s office
  – When are orders typically signed?
  – What are physician’s preferences for verbal orders?
  – What method for submitting orders?
    • Fax
    • Electronic
    • Original paper
  – Who do you call to track missing orders

Order Tracking

• Scheduling module
  – What happens to unconfirmed visits?
  – What happens to visits not on the schedule?
  – Who is responsible?
  – Who supervises the person responsible?
• No scheduling module
  – How are frequencies tracked?
  – Who is responsible?
  – Does anyone verify frequency/orders prior to submission of the final claim?
    • If all orders aren’t signed, what do you do?

Clinical Treatment and Documentation

• How do you monitor that visits are being made?
• How do you monitor that documentation is being received?
• Who is in charge?
• Who is supervising the person in charge?
• Do you verify that you have notes for all visits prior to submission of the final claim?
• What if notes are missing?
  – Do you hold the claim?
  – Submit and hope the note comes in?
RAP

• Cannot submit until
  – First visit in episode is completed
  • How does this affect recertifications
  – Plan of care has been sent to physician
  – OASIS is locked and matching key is generated
• Timeliness is important
  – Fast submission = fast payment
  – More review could = higher dollars

RAP

• Schedule for submission of RAPS
  – Daily, weekly, monthly
• Balance total claims dollars against sales journals
  – Who is responsible?
  – Who supervises this person?
• Claims monitoring – DDE
  – Check to ensure RAP was processed
  – Make corrections immediately
• RAP auto cancellations
  – Monitor for frequency and cause

Final Claim

• Can’t be submitted until
  – All orders are signed
  – All documentation is in the chart
• Schedule for submission of final claims – by payer
  – Daily, weekly, monthly
• Balance total claims dollars against sales journals?
  – Who is responsible?
  – If paper claims, who verifies they are sent?
  – Who supervises this person?
  • Medicare claims monitoring – DDE
  – Ensure that final claim is processed
  – Make corrections immediately
Medicare Timely Filing Limits

• Effective 1/1/10 have one calendar year to file claims
• Claims from 10/01/08 through 12/31/09 must be filed by 12/31/10
• No details available at the time this presentation was written
  – Based on episode start date or end date
    • Assume it will be end date
  – Based on end of month or actual date

Cash Posting

• Critical step in revenue cycle
  – Any variance noted should be immediately investigated
  – Contractual adjustments should be dealt with immediately
  – Small balances should be written off immediately
  • You define small balances
• Balance cash received with cash posted
  – Who is responsible?
  – Who supervises the person doing this?

Collections

• Partial balances – problem begins at the cash posting process
  – Variances that can’t be resolved should be addressed immediately
• Unpaid claims
  – Management needs to monitor accounts receivable on a monthly basis
    • Medicare – clean claims paid in 14 days
    • Insurance – clean claims paid in 30-60 days
• Establish profile for each insurance company
  – Typical time for payment of a clean claim
Collections

- Every quarter before signing the Medicare Credit Balance Report
  - Management should review a detailed accounts receivable aging
    - Identify any unusual balances
    - Identify any unpaid claims older than typical payment
  - Follow up with person in charge of collections on an individual account basis

Medicare Denials

- Denials – Pre-payment
  - Medicare claim can be denied (RTP) for technical reasons when submitted
    - Review of DDE after submission of claims identifies problem immediately
    - Correction of claim should be responsibility of person who submitted original claim
  - Medicare technical denials – based on information on the claim

Insurance Denials

- Insurance denials
  - Eligibility
    - Must resolve immediately – the clock is ticking
  - Lack of authorization
  - Wrong form/format
Post-payment Denials

- Must be based on request for more information
  - Medicare
    - ADR from FI
    - Investigation by RAC, ZPIC
  - Insurance
    - Less common
    - Usually massive review
  - Process must be developed for tracking any record requests involved in a claims review process

Appeals

- Who monitors pre-payment denials?
  - How is information tracked?
- Post-payment denials tracked with record requests
- Who reviews denials?
- Who decides if appeal should be pursued?
- Need tracking mechanism for all appeals

Denials, Adjustments, and Appeals

- What are the accounting transactions
  - Contractual adjustments
  - Small balance write offs
  - Pre-payment denials
  - Post-payment denials
  - Partial payments
  - Bad debts
Medical Supply Tracking

- Establish a formulary
  - You are not required to provide specific brands unless medically indicated
  - Be sure your staff understands the difference between routine and non-routine supplies and the financial effect on the agency
  - Establish a strict policy regarding routine supplies
  - Monitor routine supply usage by clinician

Medical Supply Usage and Delivery

- Drop shipments
  - Is there an established formulary?
  - Who processes orders?
  - Who approves orders?
  - When are orders processed?
  - How does agency receive invoice from supply company?
  - How do charges get entered onto the invoice?

Medical Supply Tracking

- Drop shipment of medical supplies
  - Pros
    - Less clinical staff time spent to pick up supplies
    - Usually better billing information
    - Usually requires an established formulary
    - Less work for clerical staff – don’t have to maintain full inventory
Medical Supply Tracking

- Drop shipment of medical supplies
  - Cons
    - May be delays in delivery time
    - May need to order in larger quantities for some items
    - May require nursing staff to complete orders
    - In house inventory in house for emergencies
    - Capturing billing
    - Keeping supplies on hand

Medical Supply Tracking

- In house inventory
  - Must take physical inventory
  - Must have system for tracking items removed
  - Typically requires considerable clerical time to
    - Keep stock on hand
    - Track usage for billing
    - Identify cost of items when billing
  - It's never accurate

Medical Supply Tracking

- How are final claims processed for medical supplies?
  - Changing 5th digit
- In your last fiscal year
  - What was the total non-routine medical supplies billed?
  - What was the total payment you received for non-routine medical supplies?
  - What was the total cost for non-routine medical supplies?
Results of Revenue Cycle Review

• Identify employees who do not know their responsibilities
• Identify employees who know their responsibilities, but don’t know how to fulfill them
• Identify the black holes – no one is doing these things
• Identify areas for process improvement
• Identify compliance issues
• Identify opportunities for additional meaningful data collection
• Identify cost saving opportunities
• Identify ways to improve cash flow and collections

Questions