Healthcare Dollars and $ense

ORLANDO HEALTH®

August 16, 2017

Topics

- How do we get paid – Hospital Based Services
- AR days
- Budget – what is in your control
- LOS, DC time, DRG, GMLOS
- What is the financial difference in a pt leaving at 9am vs 5pm?
- Reimbursement
- How can the front line leaders effect change?
- Charity and Bad Debt; financial assistance
- Future plans – Payment based on outcome
- Managed Care Contracts
- Payer mix - % of self pay

Revenue Management Objective

Provide an understanding & overview of the Revenue Cycle to ensure we are obtaining the appropriate reimbursement for services rendered at Orlando Health.

“not a dollar more, not a dollar less”

David Strong, President & CEO

Revenue Management Objective

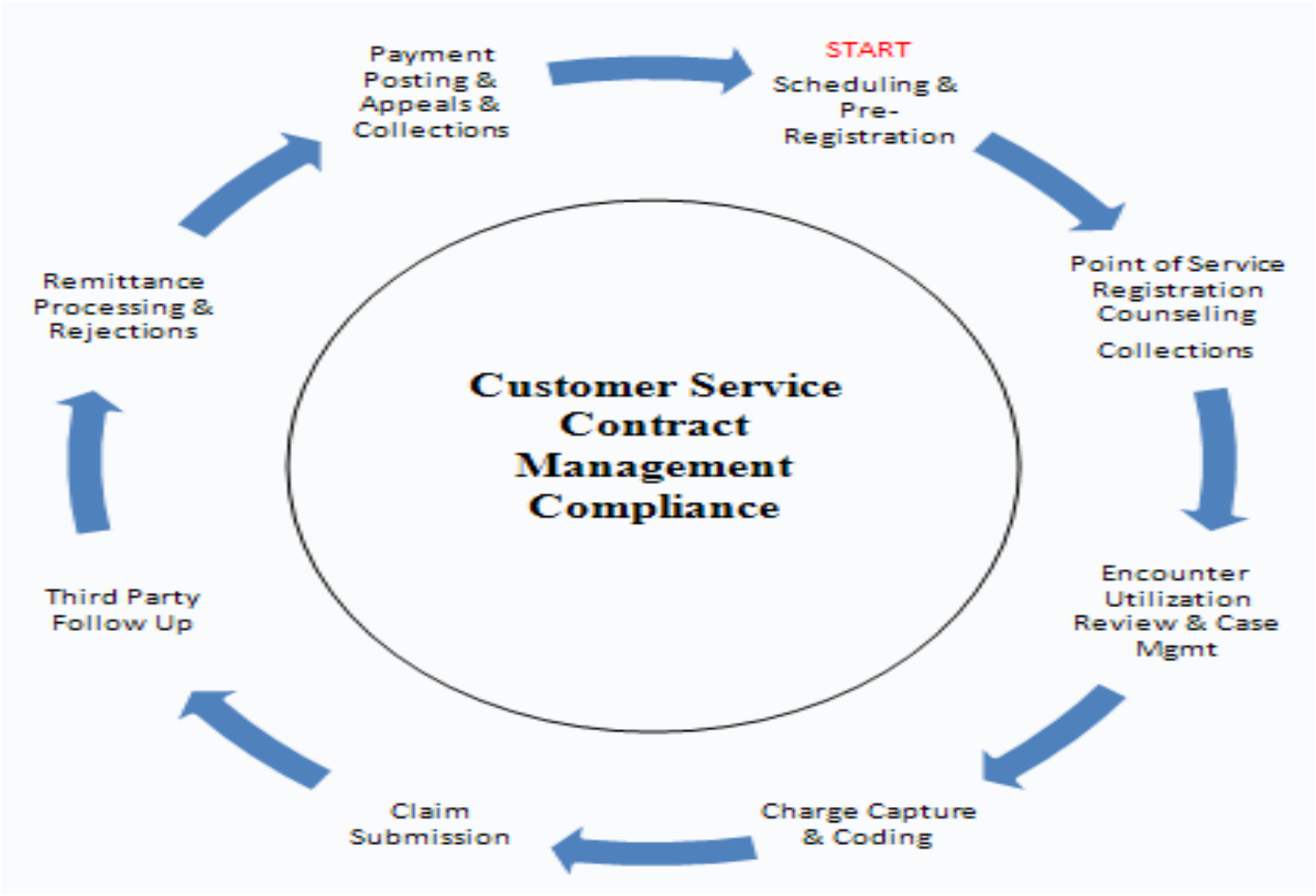
The Healthcare Financial Management Association (HFMA) defines revenue cycle as:

> **"All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue."**

This represents the entire life of a patient account from creation to payment

Revenue cycle processes flow into and affect one another. When processes are executed correctly, the cycle performs predictably. Problems early in the cycle can have significant ripple effects. The further omissions or errors travels through the revenue cycle, the more **costly** revenue recovery becomes.

Revenue Cycle



Life Cycle of a Claim: Overview

Patient Access

Essential patient information is gathered and recorded (e.g., demographics, insurance information)

Revenue Integrity

Charges are reviewed & captured

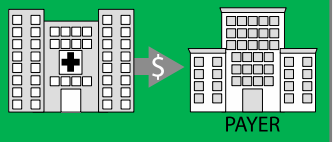
Coding & Health Information Management

Services are documented, reviewed & coded.

Concurrent Medical Record Review (RNs)

Patient Accounting

(Billing & Collections)



Claim is produced and billed. Claims are paid or denied; if denied an appeal is submitted to payor

CARE

FROM CARE TO CA$H

How do we get Paid?

Why Collect before or at time of Service?

Patient Benefits

- Reduce Stress surrounding having to pay bill later
- Encourages patient to be aware of their financial responsibility
- Helps maintain good credit ratings

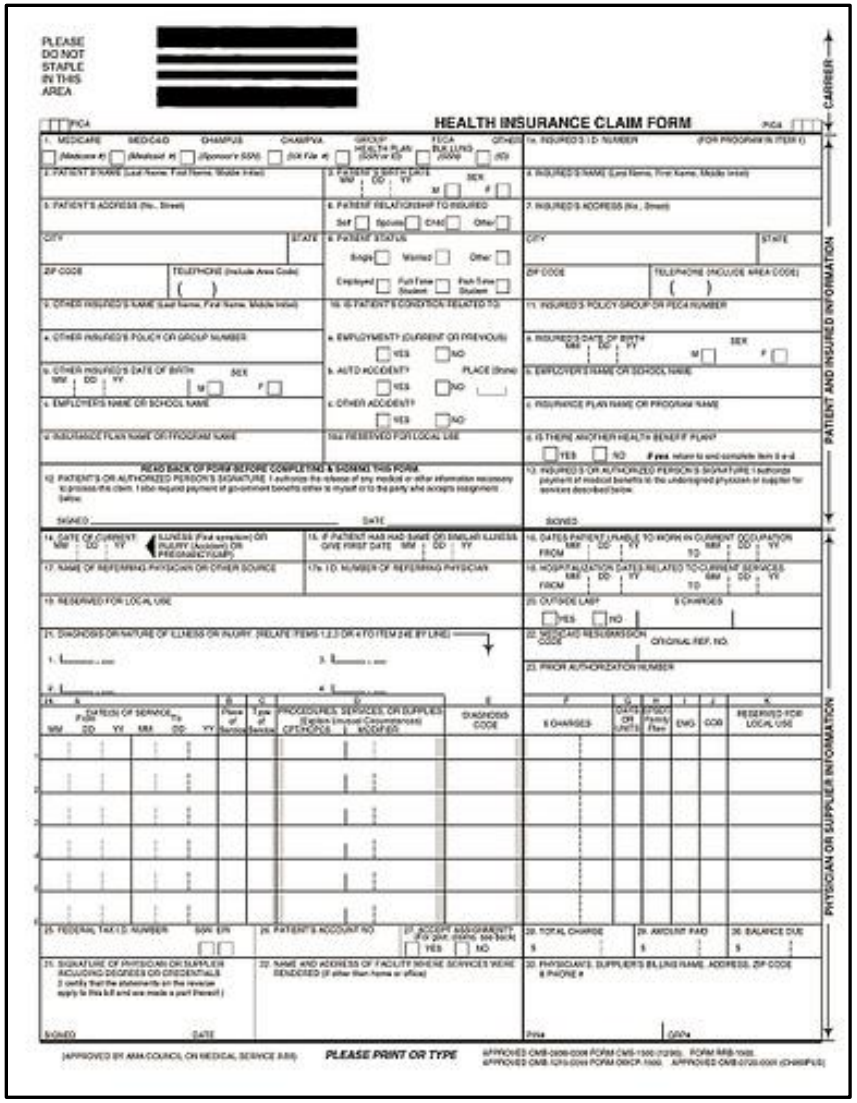
Hospital Benefits

- Avoids payment delays
- Decreases bad debt
- Helps maintain operating income
- Increases billing efficiency
  - Decreased calls on billing questions
  - Decreases number of small balance accts
  - Billing is costly –mailing statements, calling patient, collections

DRG's

- Monopoly activity – involve a few 'players'. hand out 'cash' to represent amount a DRG pays; take money back based on various reasons such as contractual adjustment, services provided that wont get paid, denial write-offs, etc

What is Required to Bill for Service?


PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

PLEASE PRINT OR TYPE

- Patient Name
- Date of Birth
- Social Security Number
- Policy Holder / Subscriber / Insured's Name
- Policy ID Number
- Policy Group Number
- Authorization Number

Revenue Integrity Department

MID-CYCLE FUNCTIONS include:

- Maintains Charge Description Master (CDM)
- Implements Medicare rules & regulations
- Identifies areas for charge capture

GOALS:

- Ensures charge capture
- Provides education across campuses to Nursing & Other Departments
- Performs charge management & reconciliation for hospital services
  - Ancillary services have charge management within clinical areas
  - Nursing is performed by Revenue Integrity

Coding &
Health Information Management Department

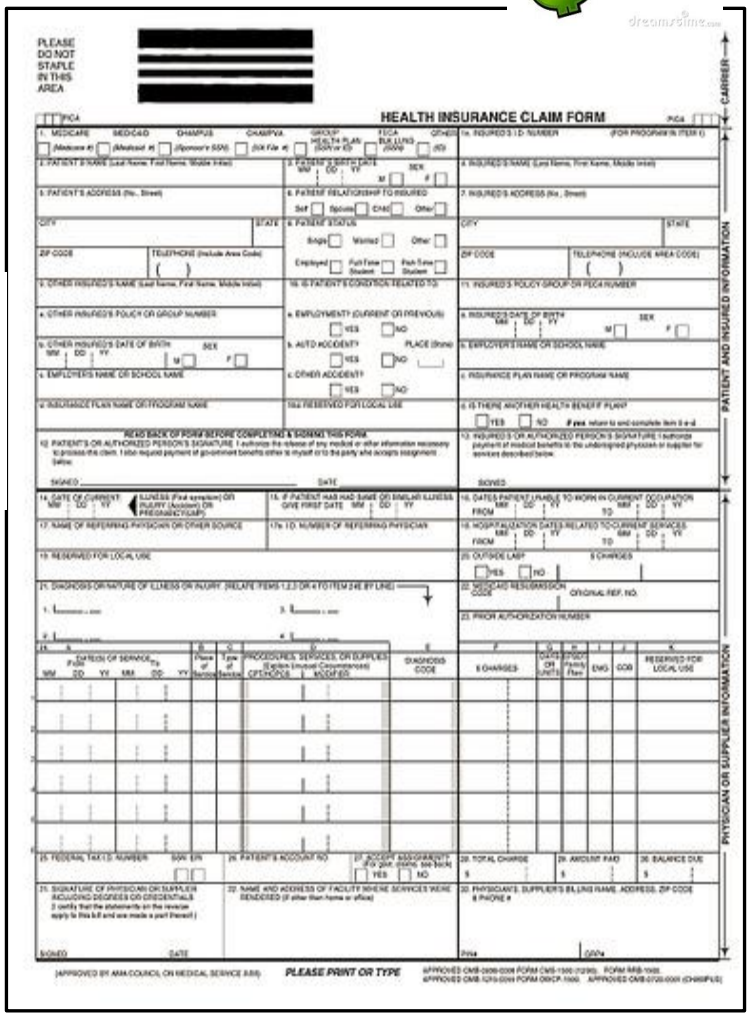
More MID-CYCLE FUNCTIONS

- Coding & Health Information Management determine **CODES** to be reported & billed on claims.
  - Supported by physician documentation
  - Impacts whether providers will receive proper reimbursement from payers.

- Can result in BOTH clinical & technical denials, which indicates importance of completed/detailed clinical documentation.

Patient Accounting Department

- Patient Accounting team members **complete** Life Cycle of Claim:
  - Worklists to manage claims
  - Appeal Denials
  - Research credit balances
  - Update data on the account
  - Call center – talk to patients
  - Accept and post payments
  - Process charity packets
  - Work with third party vendors
  - Legal research



video

Payer Mix

- Average Volumes over the years:

Discharge Orders are Written!

- What difference does it make if the patient leaves at 9am or 5pm?

Financial Metrics

- AR Days
- LOS, GMLOS
- DNFB
- Denial Write-offs
- Total Charges, Adjustments, Payments
- Bad Debt
- Community Care

How can I help?

- Expenses/cost
  - Labor
  - supplies
- Patient Access/gathering Financial and Demo Information
- Re-admissions (avoid)
- HACs
- What can I do right now to make this better?
  - PI mindset
  - Think as a business owner
  - screening services should be provided after Discharge as an OP
  - Admit orders are Signed PRIOR to Discharge

We are invested in YOU!

- Comp study – market target – August changes
- CAP Program
- Leadership development such as “Emerging Leaders” program, Book Club, Mentor Series
- SHINE/Bone-up education
- Leadership – pilot for Charge Nurses
- GEMBA
- Wellness Credit
- Daisy Award – Quarterly recognition
- Peers to You recognition
- Kudos Rounds

We are invested in YOU!

- Education
  - Continuing education
  - Training for specialized areas
  - Coordination with OH downtown for education
- Certifications
  - BLS

Glossary – Revenue Cycle Terminology

- **Charge Capture:**
  Documented services are manually or electronically translated into billable fees.
- **Claim Submission:**
  Billable fees are submitted to the insurance company via a universal claim form for payment.
- **Coding:**
  The process of transforming descriptions of medical diagnoses and procedures into universal medical code numbers.
- **Patient Collections:**
  Collecting patient balances, making payment arrangements.
- **Pre-registration:**
  Collection of all registration information, including eligibility, benefits and authorizations, prior to the patient's arrival for inpatient or outpatient procedures.
- **Registration:**
  Collection of a comprehensive set of data elements required in establishing a Medical Record Number and satisfying regulatory, financial and clinical requirements.
- **Remittance Processing:**
  Posting or applying payments/adjustments to the appropriate accounts, including rejects.
- **Third Party Follow-up:**
  Pursue collections from insurers after the initial claim has been filed.
- **Utilization Review:**
  Evaluation of the necessity, appropriateness, and efficiency of the use of medical services and facilities, which includes regular reviews of admissions, length of stay, services performed, and referrals.

Glossary – Revenue Cycle Terminology

- **Deductible**
- The amount patients pay for covered health care services before patient's insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself.
- **Copay**
- A pre-determined flat fee paid by patient/guarantor for services in addition to what insurance covers on the claim. ($20, for example)
- **Coinsurance**
- The percentage of costs of a covered health care service that patients pay (20%, for example).
- **Allowed Amount**
- The maximum amount a plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."
- **Bad Debt**
- Any bill submitted for payment by a third-party payer or patient which is not paid in full, and unlikely to be paid for various reasons.

Glossary – Revenue Cycle Terminology

- **High-deductible Health Plan**
- A plan with a higher deductible than a traditional insurance plan. Usually the monthly premium is lower, but you have to pay more health care costs yourself (your deductible) before the insurance company starts to pay its share.
- **Premium**
- The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.
- **Payer**
- The person or agency paying the bill, satisfying the claim, or settling a financial obligation.
- **Out-of-pocket Maximum**
- The most the patient has to pay for covered services in a plan year. After which the patient's health plan pays 100% of the costs of covered benefits.