RCM PROCESS DECOMPOSITION

[redacted] **BUSINESS SERVICES, PRESENTATION**

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[redacted]

REVENUE CYCLE MANAGEMENT

Executive Summary

The following document is an analysis of the RCM process. The readers may browse through the report using the hyperlinked table of contents.

Revenue cycle management is the financial process, using medical billing software, that healthcare facilities use to track patient care episodes from registration and appointment scheduling to the final payment of a balance. R.C.M. is a blended process with two front-end sub processes and two back-end sub processes. To maximize revenue and verify patient benefits, communicating with health insurance companies is a key component of RCM.

The process involves ten steps and four of these steps require [redacted] participation. The four steps are Verification, Billing, Payment Posting and Account Receivables.

The following sections gradually break down the R.C.M. process in the context of [redacted] As the report progresses, the process is broken down to finer granules. The objective of this report is to lay a foundation for optimization efforts and to showcase an understanding of the overall process.

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Overview: Brief Case Study of the [redacted] Division at [redacted]

The method of operation of the division at [redacted] is to create value through a symbiotic arrangement between an on-shore team based in [redacted] and an off-shore team operating from [redacted]. The on shore team directly participates in client briefings and business development. They relay necessary information back and forth between the off-shore operations team and the clients. The off-shore team comprises of the operations executive that are the heart and soul of [redacted] service offering. The quality of service that [redacted] can offer is bound by the quality of skills possessed by the operation executives.

The benchmark set by current/prospective clients, for successful execution of the RCM, requires [redacted] to substitute the practices' billing department. The idea is to help the client by eliminating the cumbersome task of running a billing department internally. The client's monetary interests in this arrangement are lower costs, improved AR, a 99%collection rate, and a lower rejection rate of insurance claims. Most importantly outsourcing the billing process allows clients to only incur expenses proportionate to the revenue collected instead of a fixed cost. This also incentivizes the billing company to maximize the revenue.

While [redacted] has been in the **medial billing industry for over two decades**, billing services have been added to the product line within the past two years. The team primarily comprises of internally recruited employees with experience in non- billing processes along with former employees from newly acquired U.S. based billing firm [redacted] This holds true for lower and higher management.

D*espite setting up operations and successfully delivering services for almost two years, there remains a lot of room for process* ***optimization.*** *These changes may be necessary if the leadership is committed to expanding and scaling the billing process.*

Revenue Cycle Management as a Business Process

The following section provides a multi-dimensional view of the RCM process at [redacted] by contextualizing it in relation to different stakeholders and individual sub processes. The process comprises of ten steps. The four highlighted steps are performed at [redacted]

1) *APPOINTMENT*: Practice books an appointment for the patient and collects the patient's demographics and insurance details to update the appointment module

2) *VERIFICATION:* The insurance verification form is prepped by selecting individual patients through the verification module. Patients are verified at least 3 days prior to the scheduled appointment. The insurance coverage and relevant treatment history are uploaded in the system. (Last minute appointments a.k.a. *'add-on(s)'* are done right before the date of service)

3) *TREATMENT:* Patient receives treatment, and the performed procedures are registered in the patient's ledger.

4) *BILLING:* Claims are submitted by batching procedures, adding necessary documents, adding patient-provider information, and selecting necessary clearing house.

5) *CLEARING HOUSE:* Intermediates the claim submission process between the payer (Insurance) and the biller (Provider).

6) *CLAIM ADJUDICATION:* Insurance assesses the claim to ascertain appropriate reimbursement.

7) *EXPLANATION OF BENEFITS:* An explanation of benefits and the payment are received by provider and is forwarded to Cosentus.

8) *PAYMENT POSTING:* Claim is posted or reprocessed based on the E.O.B. and denials. Patient's responsibility is estimated, and the ledger is adjusted for balances. If required A.R. team follows up with the insurance to challenge claim denials and/or acquire EOB(s).

9) *PATIENT IS BILLED:* Patient is requested to clear dues (if any)

10) *ACCOUNT RECEIVABLES:* Follow ups conducted on 30 days, 60 days, and 90 days old claims to maximize revenue collection.

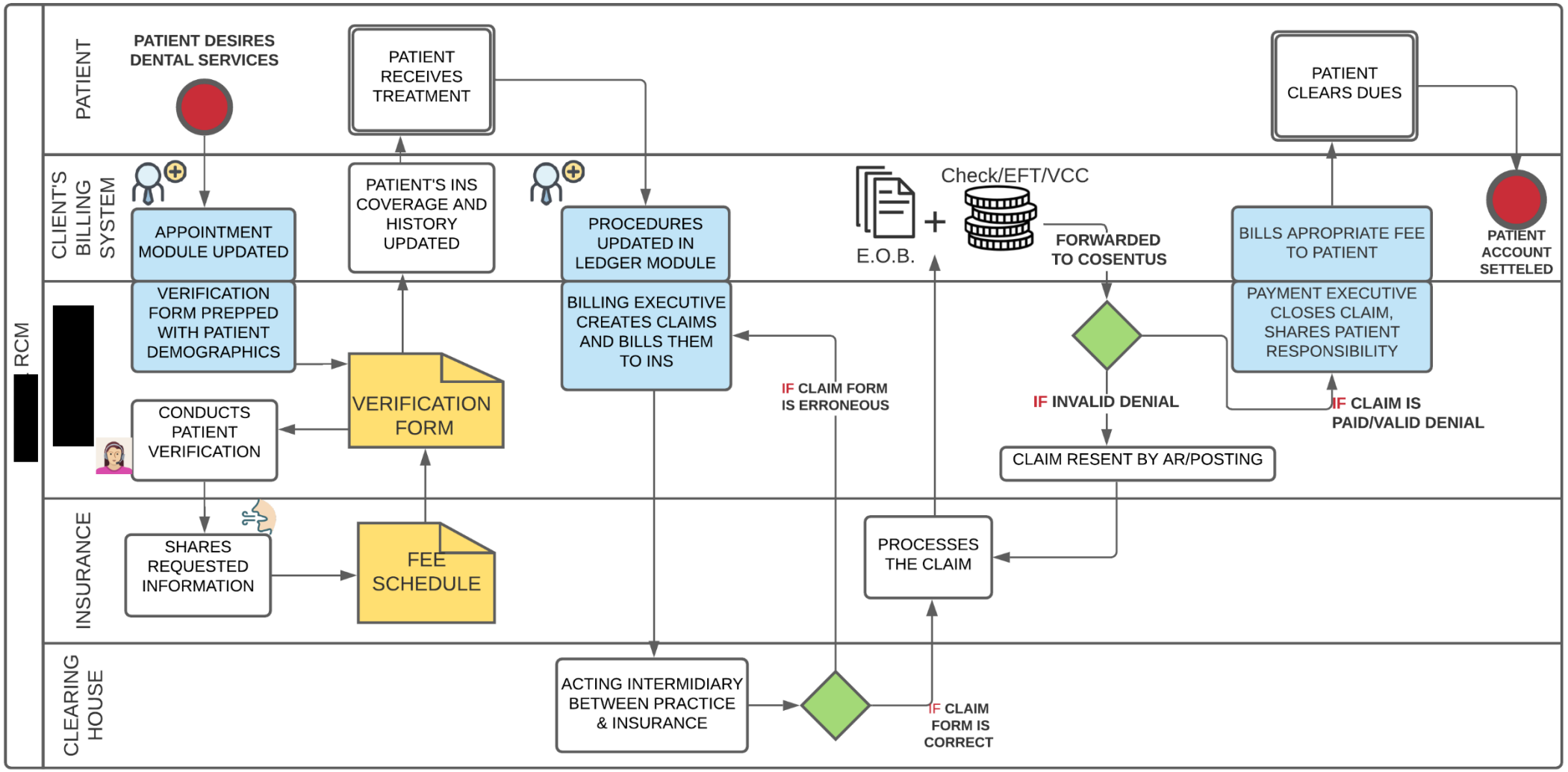

Illustration A.1 [redacted] Revenue Cycle Management Process

R.C.M. Steps Performed at [redacted]

A bird's eye view of the process is not sufficient to diagnose and fix bottlenecks. An explanation of specific sub processes and the tasks performed by executives provides insights that are relevant to our change initiative.

Verification:

Verification at its core is an information management problem i.e., to provide the right information at the right time.

In the context of RCM,

- *The right information: 'Benefits' and 'Treatment History' of a patient*
- *The right time: After the appointment has been made and before the patient visits the provider.*

The provider is interested in solving this problem to gauge the patient's purchasing capacity. This allows the provider to charge the patient and provide services appropriately. Since there are an innumerable CDT codes, the provider is interested in knowing about recurring and dollar fetching procedures. D1110 (Prophylaxis), D0274 (Bitewing x-rays), D1206 (Fluoride) are some of the procedures that are relevant to the provider. At times the practice demands verification of specific and advanced procedures for its patients. [redacted] **Insurance Verification Form** is the primary resource/medium to collect and communicate the above mentioned information.

Day To Day Tasks:

The smallest components of a process are the *tasks* that executives perform at the job in real time. A verification executive engages in the following 'Tasks'.

1) *Prepping*: Preparation of Verification forms. Executives parse through the appointments for upcoming dates of services. While doing so the basic demographic information about the patient is updated in the verification form from the family file module).

-Appointment Date -Name -Date of Birth -Insurance Company -Relation to Subscriber	- Subscriber Name & D.O.B. -Group Name & Group Number -Insurance Phone -Insurance Claim Information: -Claim Mailing Information -Payor ID

Based on daily assignments from team leads and assigned practices, an executive's shift begins by accessing a practice's system, specifically, the appointment module. Every patient is selected, and the above mentioned details are typed into a fresh verification form. The family file module is used to extract patient's personal and insurance information. Once, every patient is covered for the intended time frame, the '*prepped*' forms are placed on the common server (Local/SharePoint) for the rest of the team.

2) *Verification*: The next section of the form has a short survey detailing the benefits of the patient. To collect this information the insurance is contacted via telephone. Here, the verifier acts as a representative of the provider, and the billing company. The executive must share an American-pseudonym and verify himself as a legitimate representative of the provider. Thus, he must have access to National Provider Identification Number or the Tax ID, practice's address, and name of the practice. Thereafter, the benefits of the patient are verified.

This section is divided in to four sections: Insurance Plan Benefits, Frequencies, Downgrades and Additional Notes.

-The insurance plan benefits section involves information about overall coverage of the policy. The annual maximum (total and used), annual deductible (paid/not and whether it is waived for preventative), the name of the fee schedule, the coverage period, waiting periods, effective date of the policy, missing tooth clause (yes/no) and the overall coverage of preventative/diagnostic,

basic, major, endodontics, oral surgery, periodontics, and orthodontics services (If yes, then the orthodontics maximum and the age limit to be eligible for such benefits).

-Frequencies and history for various procedures are collected in the following section. The verifier enquires about the percentage coverage, frequency and treatment history of Oral Exams, Bitewing x rays, Full mouth x rays, Prophylaxis, Periodontal Maintenance, Fluorides, Sealants, Scaling and Root Planning.

-**Downgrades** section involves more complicated and high dollar value procedures such as composites (downgraded to amalgam, YES/NO), posterior crowns (YES/NO), crowns payment (SEAT/PREP), is build considered part of crown (YES/NO). Surgical placement of implant coverage (YES/NO), nightguards (YES/NO), Bruxism (YES/NO).

-**In the additional notes** any imperative details that were missed out in the previous sections are mentioned.

Online portals are an alternate resource for verification. These are essential for insurances that do not offer customer service over calls or cater to third party billing companies. On average a single form requires 10 mins (+/- 2 mins).

Uploading: Once the **right** information has been collected, patients' fee schedule in the management system is updated and the verification form is attached in the document central. In the following days, the patient visits the practice with intention of receiving treatment. Here the provider uses the verification resources to ascertain how much should the patient be charged and what amount of reimbursement can be expected from the insurance.

Billing:

Insurance companies must be notified that their customers have received treatment and wish to be reimbursed for the same. To do so the insurance is billed by a team of billers, who send 'claims' to the insurance companies. After thorough claim adjudication insurance ascertains the appropriate payment for the claims. It is the billers' responsibility to send necessary documents with the claim form.

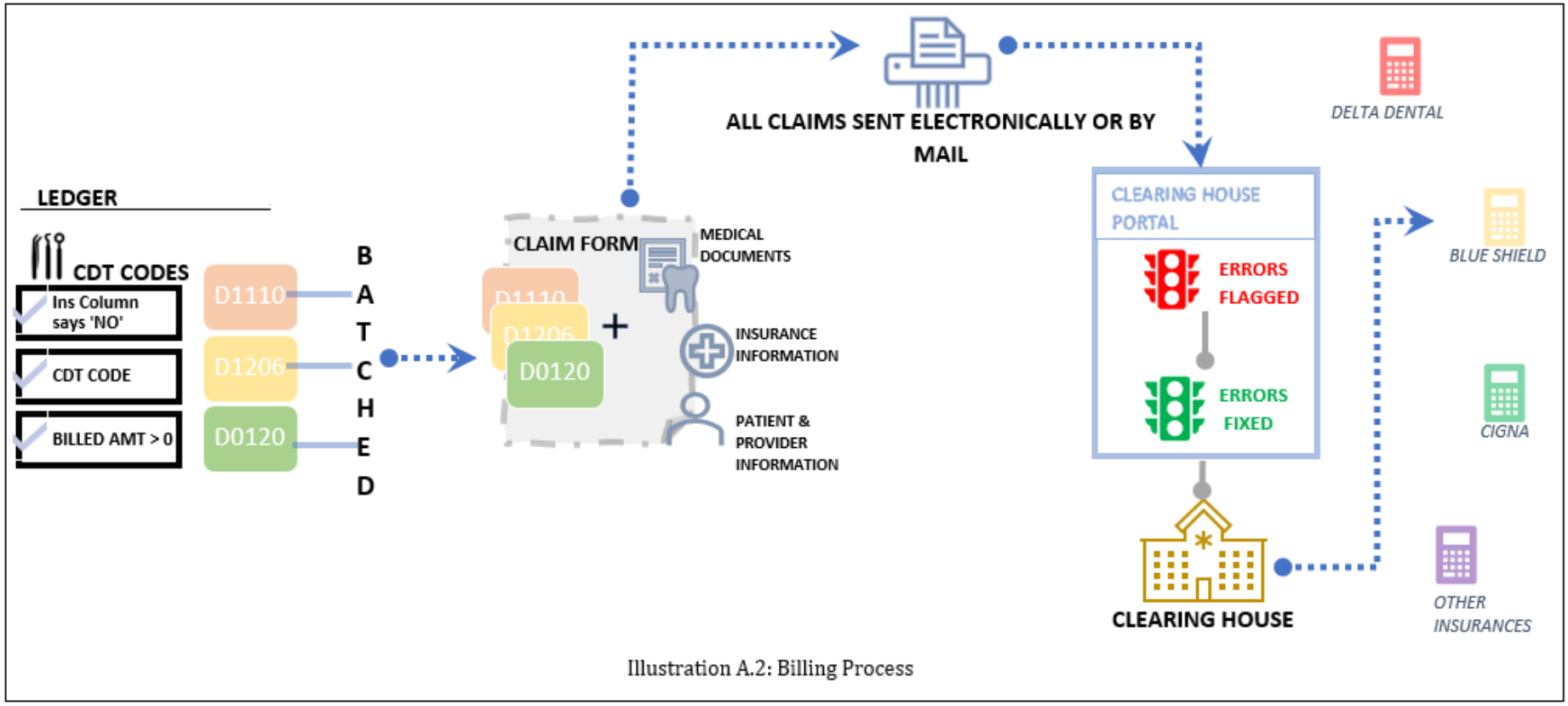

Illustration A.2: Billing Process

The tasks performed by a biller daily are follows:

1) *Sorting*: The practice's management system is accessed through a browser based remote access resource. Once in the system, appointment module is used to open individual ledgers for patients who received treatment and are due for claim submission.

2) *Batching*: The ledger for the patient is opened. In the ledger, the un-batched procedures are selected and are grouped based on DOS and are 'batched' together. These procedures are posted in the ledger by the office after the patient receives treatment. Only the procedures that have a non-zero billed amount, have 'No' in the insurance column and an appropriate CDT code are batched for a claim.

3) Follow up: Once the batching for all patients is done. The billing executive runs a 'Procedures not batched to any claim' report to see if any procedures for a specific range of dates is still not attached to any claim. If so, then the ledger for the patient with such procedures is accessed and the procedures are batched accordingly. This is done till this report is not completely blank.

4) Submission: Every time a document is attached, or a claim is batched, an automated entry is made in the 'Office Manager' module. Once the 'Procedures not batched to any claim Report' lists no unattached procedures, the biller accesses the office manager module. The entry for every batched claim is specifically selected and sent to the insurance. Based on the practice's management system, 'electronically send' feature is used or the print feature from the file section is used.

In case the billing system detects any errors in the claim forms, a warning is flashed for the biller. Once that error is fixed, the biller attempts to send the claims again.

5) *Clearing House*: If sent successfully, the claims are highlighted in the Clearing House. Three of the most common clearing houses used by every practice are [redacted]. The clearing house software/portals flash warning signs in case the claim is missing any important information. This information could be patient related details such as patient's personal/insurance information or insurance related details such as insurance address etc. The highlighted deficiencies are fixed by the biller and the claims are resubmitted. If the required information is not available, the claim is

mentioned in the daily report for review by the onshore team and if needed it is highlighted to the practice. The biller uses his knowledge and available resources to judge if any relevant documents need to be attached.

Few examples of attachments for the biller,

(A.) DXXXX requires Periodontal charting and Pre-operative X-rays
(B.) A secondary claim will require the primary EOB
(C.) An elaborate orthodontic service requires an orthodontic case/ treatment months explaining the periodic breakdown of payments for an ongoing orthodontic procedure

Finally, A daily report in *MS Excel* is maintained by the biller. This report contains an overview of the claims sent for every practice. The biller keeps an estimate of total claims sent for a client and the associated billed amount for the same.

Payment posting:

The payments and denials need to be registered in the billing management system. Insurance shares outcome of claim adjudication with the practice via mail. The practice scans and forwards these resources to the billing company.

Payment posting team accesses the mentioned documents through the internal/external SharePoint, e-mail or directly from the client's desktop.

Alternatively, posters download electronic transfers and check payments from the online portals. Once downloaded all the claims are resubmitted/posted. If the poster finds erroneous claim adjudication, the claim is forwarded to onsite or the A.R. team.

The day-to-day tasks of a Payment Poster:

- Funnelling payments for every practice from the office, A.R., and the online portals.
- Individual snapshots of claims from every file using *snip* tool.
- Reporting of entire day's work in the excel grouped by the practice and details of the check numbers, payment amounts and the number of claims.
- Posting of payments, attaching snapshots of the E.O.B.(s) to patient accounts and reporting posted dollar amounts in the daily report.

For every individual instance of posting the poster is required to take the following actions:

Once the payment poster has accessed a client's billing management system and has the EOB displayed:

1) Patient's ledger is accessed using the patient's name on the EOB. The entry/transaction for the sent claim is selected from the ledger using the date of service, total billed amount and the procedures mentioned in the EOB.

Total payments are posted, or individual procedures are itemised based on the software interface and provider's guidelines.

NOTE: If a procedure(s) has been denied inappropriately, the poster splits the claim and separates the procedure(s) from the appropriately adjudicated procedures. The remaining procedures are posted, and others are reprocessed appropriately. (Refer to note1)

2) Referring the EOB, the mode of payment is selected, and the unique payment number is entered.

Here the poster makes a judgement of whether any credit/debit adjustment must be made. Some of the variables that effect this decision are the in/out of network status of the provider with the insurance, the difference between payment received (from patient and insurance) and amount billed.

3) After the appropriate adjustment is made, the payment is posted. If the patient has no open claims and has a balance of over $5. The patient is sent billing statement.

The poster must make a note of the patient's responsibility and the reason for denials.

4) With the completion of every file and/or check, the report in excel is updated. Once, all files are processed, for posting/appraisal/resubmission, a deposit slip is requested from the office manager tab.

Using the Deposit Slip the work is reconciled in four ways, -Total payments in report match the total in deposit slip -All entries have the correct mode of payment -The payment identification number for all entries is correct -Every payment that was reported in the excel for the client has been posted. If not, then the adjacent remarks should reflect the explanation.

Working on Denials:

- *Valid Denials*: A fair denial of benefits from the insurance is posted as a zero-dollar payment. The patient is billed for these services according to his/her contract.

Some of the valid denials are:

- Procedure not covered in contract
- Frequency for the service has been exceeded
- Annual maximum exceeded
- Waiting period not completed

- Procedure performed on a tooth extracted before the policy began and the contract has no missing tooth clause.
- Policy terminated/Benefits received before coverage started (and the patient has no other insurance coverage)
- Payment for the service is paid as part of another procedure
- The payment not made due to age limitations

- *Missing Medical information*: There are instances where the insurance requests additional information or denies a claim stating that the procedures have been 'deemed not necessary'.

The payment executive must attach the requested information and resubmit the claim. He/she may need assistance from a Biller to find and attach the appropriate document. A list of such documents is as fo:

- X rays: Bitewing, Full-mouth, Panoramic, Periapical
- Clinical notes/Narratives
- Primary Explanation of Benefits
- Prep/Replacement date
- Incomplete EOBs: In case of missing remarks, poorly visible EOBs or missing checks/EOBs, the payment poster must try to find an alternate resource. If, no alternative is available, the payment is highlighted in the report and forwarded to the onsite team or the Account receivables team.
- Carriers Risk Assessment code is missing

- *Missing/Incorrect Demographic information*: At times insurance specifies a certain piece of information that reflects the patient's or the provider's demographic details. The poster must search and add the omitted information and resend the claim. This information could be found in the Family File module or the Document Central. The verification team or the claim submission team could be approached for assistance.

  - Patient member ID does not reflect any customer in the insurer's database
  - Rendering provider is not contracted
  - Incorrect provider information

Adjustments:

An Adjustment is made to address and account for the portion of a payment (patient + insurance) that is:

1) More than the billed payment
2) Less than the billed amount

- *DEBIT*: In case the provider is ensured an aggregate payment (Payment from Insurance plus payment from patient) greater than the billed amount, the account for the patient is debited by the difference.
- *CREDIT*: In case the provider ensured an aggregate payment (Payment from Insurance plus payment from patient) lesser than the billed amount, the account for the patient is credited by the difference.

Account Receivable:

Roughly 70% of the payments are received by the practice and are processed by the posting team with no hiccups. However, there are claims that are successfully billed and an acknowledgement from the insurance is never received. The A.R. team is responsible for following up with the insurance and requesting an update on these unprocessed claims.

The A.R. team works on three separate buckets of open claims:

- More 90 days old claims
- 90 days > 60 days old claims
- 60 days > 30 days old claims

The insurance companies are given 30 days to process the claims. If the claims are processed, these claims are fetched by summoning the aging report. An aging report is a list of open claims in the billing management system. A competent A.R. team aims at keeping the aging report as clear as possible.

Once, the aging report for a practice is produced, the A.R. executive filters out the high dollar value claims and selects the claims that he/she will be working on. He then proceeds to place calls to the insurance company or access the insurance company's online portal.

Online portals and direct calls are mediums to collect Explanation of Benefits for the claims that the executive is interested in. Once, an update is received the A.R. performs relevant action on the claim.

1) If paid/denied appropriately, the EOB is forwarded to the payment posting team. The A.R. executive must collect the E.O.B. from the insurance. Without the EOB, the payment cannot be posted and another A.R. call will be required.
2) If it is denied inappropriately, the A.R. executive appeals to the insurance representative to reprocess the claim.

3) If the insurance requires additional information that can be shared over the phone such as 'Prep/Replacement Seating', 'Tooth Number' or 'Initial seating date', the A.R. executive shares the information and follows up in another two to three weeks.
4) If, additional documents are requested the requested documents are attached and resubmitted with a new claim or shared over mail, e-mail, or fax with the insurance.
5) If there is no claim on file, the A.R. executive asks the following questions:

    - Did the patient have coverage on the Date of Service?
      If, the patient has no coverage, the patient's account is checked for alternate insurance coverage. In case there is no alternate coverage, the patient is billed. If, patient does have coverage with the insurance, the A.R. executive is interested in knowing the Payer ID.

    - What is the correct PAYER ID for the insurance company?
      If, the Payer ID is incorrect, the correct Payer ID is requested and is updated in the Family File module. This also explains why the claim was never received by the insurance. If, the Payer ID is also correct. The insurance representative is enquired about the T.F.L.

    - What is the Timely Filing Limit for the claim?
      If, the T.F.L. has passed, the A.R. executive attaches an appeal along with the claim. This appeal requests the insurance to process the claim and highlights the reasons why the claim submission was delayed.

If, the patient does have coverage on D.O.S., the Payer ID is correct and the Timely Filing Limit has not passed, the claim is resubmitted. The insurance company is given another two to three weeks to be process the claim.

The A.R. representative maintains a report in MS excel known as 'THE CALL SHEET'. This daily call sheet lists the claims that were worked on a specific day by the executive. Here, the A.R. executive details the status for the claims in detail. These details follow a specific template.

The following templates are used to add remarks for the mentioned scenarios:

- The Claim is paid by a Single Check:

> Called ___*Insurance Company's Name*_____ @ ___*888-INS-PhNo*__, *spoke with* _____*Insurance Representative's name*_____. *He/She stated that the claim was received on* __*MM/DD/YYYY*__ *and processed on*__*MM/DD/YYYY*__. *T*he claim was paid by a single Check #____Check Number___ of $XX.YY on __*MM/DD/YYYY*__ *and cashed on* __*MM/DD/YYYY*__. *Pt responsibility* ___*$XX.YY*_____. Explanation of Benefits requested. Claim # __Claim Number__, Call Reference# ____Call Ref#___.

- The Claim is paid by a Bulk Check:

> Called ___*Insurance Company's Name*_____ @ ___*888-INS-PhNo*__, *spoke with* _____*Insurance Representative's name*_____. *He/She stated that the claim was received on* __*MM/DD/YYYY*__ *and processed on*__*MM/DD/YYYY*__. *T*he claim was paid by a Bulk Check #____Check Number___ of $XX.YY on __*MM/DD/YYYY*__ *and cashed on* __*MM/DD/YYYY*__. *The paid amount for the claim is* *$__XX.YY__ Pt responsibility* ___*$XX.YY*_____. Explanation of Benefits requested. Claim # __Claim Number__, Call Reference# ____Call Ref#___.

If the claim is paid by an Electronic Fund Transfer or a Virtual Credit Card, the appropriate mode of payment is mentioned along with the unique payment identification number.

- If the claim is not paid due to a valid reason:

> Called ___*Insurance Company's Name*_____ @ ___*888-INS-PhNo*__, *spoke with* _____*Insurance Representative's name*_____. *He/She stated that the claim was received on* __*MM/DD/YYYY*__ *and processed on*__*MM/DD/YYYY*__. *T*he claim was denied as _____**REASON FOR DENIAL**_____. *Pt responsibility* ___*$XX.YY*_____. Explanation of Benefits requested. Claim # __Claim Number__, Call Reference# ____Call Ref#__.

- If the claim is not paid due to an invalid reason:

> Called ___*Insurance Company's Name*_____ @ ___*888-INS-PhNo*__, *spoke with* _____*Insurance Representative's name*_____. *He/She stated that the claim was received on* __*MM/DD/YYYY*__ *and processed on*__*MM/DD/YYYY*__. *T*he claim was denied as _____**REASON FOR DENIAL**_____. *The claim has been* __*Action Taken by the A.R. Executive*___. *Please, allow two to three weeks for follow up.* Explanation of Benefits requested. Claim # ___Claim Number___, Call Reference# ____Call Ref#__.

- If the claim is not on file:

> Called ___*Insurance Company's Name*_____ @ ___*888-INS-PhNo*__, *spoke with* _____*Insurance Representative's name*_____. *He/She stated that there is no claim on file.* The patient was eligible for benefits on Date of Service. The Payor ID is correct. The timely filling limit is ____XX months___. Hence, claim resubmitted. Call Reference# ____Call Ref#__.

The collected Explanation of Benefits are placed in a folder for the payment posting team. The payment posting executives post these payments and use the above mentioned remarks as a point of reference.

Concluding Remarks

A breakdown of the R.C.M. process to its sub processes and individual tasks will enable effective optimization efforts in the later parts of the project. To fine tune the process, a benchmark for performance metrics of executives and the sub-processes will be required.

Please, share your reflections and feedback, thank you for reading!
