MICHAEL J. TEGEDER

● Cell: 312-339-2062 ● Home Office: 773-942-6367 ● tegeder312@gmail.com

CAREER SUMMARY

Healthcare Finance professional that is multi-faceted, efficient & reliable professional with 16+ years of experience in process improvement, customer service, finance, training, refunds, and collections. Innovative and collaborative problem solver that strives to exemplify the mission, vision, and values of the partnering organization. Strong strategic business acumen with extensive knowledge of hospital revenue cycle operations including but not limited to hospital operations, billing & collections, patient access, information technology, strategic planning, and employee engagement. An independent consultant that offers a varied skill set covering administrative support, client relations, human resources, and account and project management. I provide excellent interpersonal, phone and digital communication skills as well as staff management. An experienced project manager that possesses the technical skills that assist in identifying and solving problems, improving the workflow process by performing gap analysis and reviewing metrics.

PROFESSIONAL EXPERIENCE

INDEPENDENT CONSULTANT/CONTRACTOR 7/23 to Present
Revenue Cycle Optimization Independent Consultant
Collections & Process Improvement Consultant
Various Facilities

- Created a Call Center Gap analysis report, combining reports from Epic and Cisco CUIC to analyze gaps in staff performance.
- Created Call Center Agent Call report to show Agent Inbound/Outbound calls vs goals and other staff. Report includes KPIs of call duration, time between calls, and Agent availability.
- Created Claims Denial dashboard. Use report from Epic to determine Top 10 classifications such as Payor, Physician, Department, Denial Reason, and outcome to determine actual causes of denials.

Finance Revenue Analyst
ALKU assigned to Lurie Children's 6/22 to 6/23

- Assisted in making the Annual GME process more efficient by reformatting New Innovations reports used for GME reconciliation and restructuring these reports to meet the needs of Medicare Cost and HRSA annual reporting. Automated comparison of current to previous years Decreased time commitment of two weeks to one day.
- Analyze financial data to identify trends and patterns that can increase the organization's revenue based on GME and HRSA funding. Developed report to show residency hours by program, specialty, resident year, gender, etc.

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- Collaborated with the Accounting and IT departments to automate various repetitive tasks within the financial department using Power Bi, Power Query, which reduced hours of manual data entry leading to a decreased error rate. Removed ongoing issue of errors caused by manual data entry.
- Trained account staff how to use specific financial reporting tools created in Excel, improving operational efficiency.
- Created excel dashboards for GL and Bad Debt day to day comparisons using date gathered from Crowe, Workday and Epic G/L.
- Building relationships with executive leadership, business stakeholders, and subject matter experts through in-person meetings and email interactions to decipher complex problems and needs for weekly, monthly yearly reporting and reconciliation.
- Managing large and complex data sets from various platforms and discovering ways to automate and/or optimize current processes.
- Conducting and presenting in-depth analyses to understand root causes of business trends and pinpoint operational opportunities to add value.

Single Billing Office Specialist 5/19 to 1/21

Wolcott, Wood & Taylor, Inc.

- Investigate and resolve all patient billing issues and concerns while preventing escalations for further review.
- Create KPI dashboards and software-based tools.
- Quickly and effectively, resolve customer concerns and issues with minimal handoffs to other departments.
- Perform tasks such as insurance coverage changes, rebilling, process patient payments, initiate refund requests, obtaining IBs/Statements for patients, etc.
- Deescalate patient complaints by listening, being empathetic and compassionate to the patients' needs and requests as assigned by Director or Senior Leadership.
- Work with multiple billing, payment, and eligibility systems to ensure proper research of accounts is complete before determining the best course of action on the account.
- Developed relationships with all ancillary departments within WWT and UIC for assistance with escalations.
- Create payment plans, provide patient discounts, and review non-covered char0ges for appropriate discounts.
- Review aged Bad Debt, Self-Pay and Legacy Payment Plan reports and spreadsheets for leadership and Director.
- Work with Pre-Collect and Bad Debt vendors to resolve missing payments, issues and return accounts to client.
- Worked with Pre-collect and Bad Debt vendor to improve reporting documents and reduce number of emails and reports.
- Created Cisco Finesse reporting to monitor phone metrics KPI (i.e. call abandonment rates, call wait times, volume, RONA, etc.).
- Created automated external KPI reporting in Excel using Get & Transform and M for above.
- Created or improved Excel based tools for team use such as discount calculator, call log, SBO contact sheet and more to be able to maneuver through after call tasks more efficiently while being eco-friendly.
- Developed and documented processes for SBO workflows as they are needed and requested by management.

Train SBO and UCB staff on McKesson, Epic functions and processes for SBO.

Selected as Superuser for 2020 EPIC implementation. Initiated proactive training during Go Live.

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INDEPENDENT CONSULTANT/CONTRACTOR 1/17 to 1/19
Revenue Cycle Optimization Independent Consultant
Collections & Process Improvement Consultant
Various Cities and Facilities
Independently subcontracted with facilities and other independent contractors to provide policies, identify revenue loss, improve WQ set up, leverage remittance code tables to streamline denials due to authorizations and administrative vs. clinical denials. Designed and created policies and procedures.

- Trended revenue cycle metrics and measures, including but not limited to self-pay accounts receivables (AR) days, aged AR, patient cash collections, call abandonment rates, call wait times, bad debt write offs, staff productivity and work quality, credit balances to identify area for improvement.
- Optimize cash collections by creating, monitoring, and updating work plans, strategies, and solutions toward improved performance of self-pay collections.
- Creation of Insurance and Self Pay Follow-Up policies, procedures, and workflows for Epic Client.
- Identify areas of opportunity and improvement by providing recommendations for workflow, productivity, and quality.
- Created training materials for Customer Service, Insurance & Self Pay Follow-Up, Denials Management and Refund Teams.
- Assisted in reducing the Blue Cross and Managed Care Aged A/R (91+) by 10% over a six-month period by proving the additional information needed to adjudicate the claim and collector workflows and follow up methods for escalation at a community hospital in Chicago.
- Conducted an extensive analysis of rejected claims based on remit codes; identified issues issue of authorization/certifications not attached to the claims and medical records requests not being fulfilled.
- Analyzed patient accounts for most efficient avenue to pursue timely reimbursement from insurance companies according to the insurance contract policies, procedures, and situational guidelines.
- Displayed a strong track record of account resolution through using firm yet customer-oriented collection tactics resulting in decreased delay tactics on the payer's part.
- Set time frames and actions for note types and billing activities to ensure proper follow was completed.
- Designed workflows and processes for collections, refunds and underpayment teams. Analyze reports and accounts to identify trends and close the gap on lost opportunity.

Process Improvement and Documentation Consultant/Manager 1/17 to 12/18
UF Health, University of Florida at Gainesville, Gainesville FL
Independently contracted to identify areas of opportunity and improvement by providing recommendations for workflow, productivity, and quality. Designed and created policies, procedures, Visio, and training material for both existing and newly created workflows. Managed in upwards of 15 staff on an interim basis for A/R Collections and Customer Service.

Managed 4 projects simultaneously for Revenue Integrity – Charge Capture and Audits, HIM-Medical Records Retrieval, Customer Service – Call Center Workflows and A/R Follow-Up and Training.

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- Maintain revenue cycle metrics and measures, including but not limited to self-pay accounts receivables (AR) days, aged AR, patient cash collections, call abandonment rates, call wait times, bad debt write off, staff productivity and work quality, credit balances, and overall patient/employee satisfaction.
- Optimize cash collections by creating, monitoring, and updating work plans, strategies, and solutions toward improved performance self-pay collections.
  Contributed to the Financial Assistance application workflow in Epic to ensure compliance with 501(r) and State regulations.
- Designed processes for disputed accounts from an SBO perspective through escalated calls in Customer Service.
- Condensed previous 42 page training document to 7 page for Third Party Charge Audits within the EPIC Correspondence Module; this avoided manual tracking of scheduled audits and provided realistic trackable outcomes. Reduced turn around from 14+ days to same day (outpatient) and 48 hour (inpatient).
- Created and updated facility Core Policies and Department policies as requested; Audits, Refunds, Patient Billing, Customer Service Phone Monitoring, Insurance Follow Up, etc.
- Designed training material for insurance follow up, credit balance analyst and Customer service workflows.
- Created, modified, and gathered RFI and RFP data for Early Out, Small Balance Insurance Collections and Bad Debt.
- Served as an SME for automated patient refunds process in addition to assisting in the WQ build for SBO.
- Assisted in the completion and implementation of the ADR Process within the Correspondence Module to provide timelier turnaround of medical records sent to Medicare; this increased the number of paid claims that was being held for additional document review.
- Executed the way medical records were obtained by in-house auditors; this reduced the waiting period for records, allowed for the min. necessary to be sent based on request information and better tracking of where records were released.
- Assisted in the design and implementation processes for new phone system regarding collectors; this allowed for improved productivity tracking and quality measures for management use.
- Redesigned the CDM Maintenance process to capture changes throughout the year for more timely system updates.
- Created Visio and documented workflows for existing processes that had not been documented before; enabled changes of prior workflows to be updated to a more streamline process.
- Assisted in the creation of Billing Activities specific to collector actions; resulted in a weighting system and more accurate tracking of activities for higher productivity numbers calling for an increase from 40 accounts per day to 55 accounts per day.

Rush University Medical Center – Chicago, IL
Financial Counselor 8/16 to 1/17

Evaluated patients for coverage eligibility and financial assistance.

- Processed Financial Assistance Applications (FAP's) when applicable.
- Determined Bad Debt status.
- Obtained patient demographics, insurance information and ID for all patients arriving for admission.
- Validated insurance information for all admissions (OP/IP) for pre-authorization based on service.
- Discussed OON responsibility with patients and options for payment.
- Obtained patient signatures for Consent to Treat & Financial Responsibility.

Rush University Medical Center – Chicago, IL

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Collector/Credit Balance Analyst 10/14 - 08/16

- Identified and resolved charge capture issues resulting in 9.2M of overcharges by performing an in-depth analysis of a significant increase in the credit balance A/R. This proactive approach eliminated unnecessary recoups by working directly with the payer on the refund process for the project.
- Created a contract matrix in Excel that links directly to the managed care contracts for both Rush University Medical Center (RUMC) and Rush Oak Park Hospital (ROPH)
- Standardized financial recovery reports to guarantee time frames of refund requests were adhered to by meeting with the payer for a mutual agreement of data sets and fields required by both parties.
  Demonstrated proficiencies in the reduction of accounts receivables, resolution of underpayments, management of credit balances.
- Became familiar with the managed care contract language for multiple payers as it pertains to COB, and filing limitations for timely claim filing, appeals, retro termination, and re-admission clauses as they related to overpayments and follow-up.
- Acquired knowledge of managed care contract payment methodologies in order to dispute refund requests the payer might not be entitled to due to carve outs and exclusions.
- Performed COB clause calculations to reduce the amount of overpayments processed saving 2.3M, which was booked to income.

Rush University Medical Center – Chicago, IL
Follow-Up Collector 04/14 - 10/14

- Assisted in reducing the Blue Cross Aged A/R (91+) by 10% over a six-month period by proving the additional information needed to adjudicate the claim.
- Conducted an extensive analysis of rejected claims, which identified the issue of authorization/certifications not being attached to the claims for timely payment.
- Displayed a strong track record of account resolution through using firm yet customer oriented collection tactics resulting in decreased delay tactics on the payers part.
- Successfully resolved aged/ high dollar out of network accounts as a special project by creating an escalation spreadsheet for the payer to review with all supporting documentation needed thus leading to 2.3M in combined cash collections for RUMC and ROPH at year end.
- Worked with BCBS to identify obtain benefit information on-line when receiving rejections for non-covered services discovering.
- Secured check/voucher information of issued payments and retractions on clearing accounts in order to resolve open A/R and credit balances.
- Facilitated conference calls between patients and payers to obtain COB or accident information needed for claims processing resulting in claims being released for payment.
- Reviewed and corrected DNB errors for both RUMC and ROPH via information provided by MD or RN in Report Viewer or working with HIM from appropriate hospital.

Microsoft MO-200: Microsoft Excel (Excel and Excel 2019) Certification 08/21