Velden Health Tool User Manual

A Comprehensive Guide for Velden Revenue Pulse Tool v1.0

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Velden Revenue Pulse – User Manual

1. Introduction

Velden Revenue Pulse is an internal audit tool designed for behavioral health clinics. It helps you quickly assess the health of a clinic's Revenue Cycle Management (RCM) across five key areas: tech stack & ownership, intake & eligibility, claims & posting, A/R & denials, and reporting & compliance.

This user manual explains each part of the tool, what the questions mean in real life, and how to use the results on a live call with a provider. The goal is simple: help you confidently run a 20–30 minute RCM audit and convert that conversation into a clear case for working with Velden Health.

2. Page Layout & Main Elements

2.1 Top Bar & Branding

• The top bar shows the Velden Health SVG logo and the label "REVENUE PULSE AUDIT – Behavioral Health · RCM Audit".
• On the right, there is a small pill that says "Internal use with clients · Do not share publicly".
This is your reminder that the tool is for internal use only and not a public marketing page.

2.2 Header Block

Below the top bar, you see a white header card with:
• Title: "RCM Audit for Behavioral Clinics".
• Subtitle: a short explanation that this is a 20-question review used to surface revenue leaks.
• Pills: quick hints such as "~30 min live audit", "0–2 scoring · red / yellow / green", and "PDF summary you can email after the call".
• Metric card: On the right side, you see a small metric card with "Today's focus – 3 clinics through this tool". This is just a mental nudge for you to actually use the tool with real practices, not keep it theoretical.

2.3 Section Navigation

Under the header, there is a horizontal navigation made of small rounded buttons:
• Practice profile
• Tech & ownership
• Intake & eligibility
• Claims & posting
• A/R & denials
• Reporting & compliance

Clicking any of these will smoothly scroll the page to that section. Use this during a call to jump quickly instead of manually scrolling.

2.4 Main Cards (Sections)

The main content of the page is split into separate white cards:
• Practice profile
• Section 1 – Tech stack & RCM ownership
• Section 2 – Intake & eligibility
• Section 3 – Claims submission & payment posting
• Section 4 – A/R & denial management
• Section 5 – Reporting, KPIs & compliance
• Actions & Results (buttons + score area)

Each section has a title, a brief description ('section-help' text), and a series of questions.

3. How Scoring Works

The tool uses 20 questions. Each question is scored from 0 to 2 points:
• 2 points = strong system or best practice.
• 1 point = partial, inconsistent, or medium-strength practice.
• 0 points = weak, missing, or risky practice.

Maximum total score: 20 questions × 2 points = 40.
The tool then converts this into a percentage:
• Percentage = (Total Score ÷ 40) × 100.

Risk bands:
• 0–50% = RED RISK – RCM is fragile and revenue is at risk.
• 51–75% = YELLOW RISK – Core pieces exist but there are meaningful leaks.
• 76–100% = GREEN RISK – Solid RCM foundation; focus on optimization and automation.

4. Practice Profile (Section 0)

This section is for context only. It does NOT affect the score.
Fields:
• Practice name – Name of the clinic (e.g., "Sunrise Behavioral Health").
• Contact person – Who you are talking to (owner, practice manager, billing lead, etc.).
• Clinic type – Solo / small group / larger group. This shapes how you frame recommendations.
• Approx. monthly sessions – Rough volume. Helps later when you estimate impact (e.g., number of claims per month).

5. Section 1 – Tech Stack & RCM Ownership

Goal: Understand the clinic's core systems and who actually owns the revenue cycle work.
Each question has an "i" button that opens an information panel with detailed explanations.

5.1 Question 1 – Primary EMR/EHR and clearinghouse setup?

Concepts:
• EMR/EHR: The software where providers document visits, diagnoses, and clinical notes.

For our purpose, this is the central system of record for sessions.
• Clearinghouse: A middle layer that checks ("scrubs") claims and routes them to payers. A good clearinghouse catches basic errors before a claim reaches the payer.

Options:
• Behavioral EMR + integrated clearinghouse (score 2)
– The clinic uses a behavioral health-specific EMR.
– Claims are generated and sent via a built-in or tightly integrated clearinghouse.
– Fewer manual steps, fewer basic errors.

• Behavioral EMR, partial / manual clearinghouse (score 1)
– The clinic has an EMR, but still downloads files, uploads to a separate clearinghouse, or keys things manually.
– More places to make mistakes and delay claims.

• No proper EMR or no clearinghouse (score 0)
– They may use paper, spreadsheets, or non-health tools.
– Claims are often messy, late, or missing.
– This is a major opportunity for Velden to bring structure.

5.2 Question 2 – Who owns the billing work day-to-day?

This question checks whether there is clear ownership. When everyone "helps a bit", no one feels responsible.

Options:
• Dedicated in-house or external RCM specialist (score 2)
– One person or one team (internal or outsourced) clearly owns billing, A/R, and denials.
– Easier to hold someone accountable and to improve.

• Shared between front desk / therapists (score 1)
– Billing is a side-task.
– It gets pushed down when the clinic is busy.

• No clear owner / ad hoc (score 0)
– Work happens only when something breaks.
– Money often gets stuck for months.

5.3 Question 3 – Written SOPs/checklists for billing steps?

SOPs (Standard Operating Procedures) turn individual habits into repeatable systems.

Options:
• Yes, documented and followed (score 2)
– There are written steps or checklists for key tasks: eligibility, charge entry, claims submission, payment posting, A/R follow-up.

– New staff can follow them and not rely on memory.

• Some notes but inconsistent (score 1)
– Some steps are written, but every staff member still improvises.

• No written process (score 0)
– Everything lives in people's heads.
– If one key staff member leaves, revenue can collapse.

5.4 Question 4 – Typical lag from session to charge entry?

This measures time from providing care to entering the charge in the system.

Options:
• Same day / next day (score 2)
– Revenue cycle is fast and cash flow is predictable.

• 3–7 days (score 1)
– Acceptable but leaves money sitting unbilled.

• More than a week / no idea (score 0)
– High risk. Many services may not be billed in time or at all.

6. Section 2 – Intake & Eligibility

Goal: Check how disciplined the clinic is at verifying coverage and capturing benefit details before the first visit.

6.1 Question 5 – Eligibility & benefits checked before first visit?

Eligibility is verifying coverage status and key benefit information before the patient comes in.

Options:
• Always, for every new patient (score 2)
– Strong front-end process, fewer surprise denials.

• Sometimes, not consistent (score 1)
– Staff know they should do it but skip when busy.

• Rarely / never (score 0)
– They often discover coverage issues only after a denial.

6.2 Question 6 – Level of detail captured (deductible, copay, limits)?

This asks how deeply they document benefit details.

Options:

• Standard template: deductible, copay, limits, telehealth (score 2)
– They use a consistent format and capture key fields.

• Some details, not standardized (score 1)
– Quality depends on who called and what they asked.

• Only active/inactive or nothing (score 0)
– They are essentially guessing patient responsibility.

6.3 Question 7 – Where are eligibility notes stored?

Even if they check benefits, it's useless if no one can find the notes.

Options:
• Inside EMR in a consistent place (score 2)
– Anyone can quickly open the chart and see coverage details.

• External sheet/notes but somewhat organized (score 1)
– Information exists but is outside the EMR.

• Scattered (emails, paper, memory) (score 0)
– Chaos. High risk of repeating calls and missing details.

6.4 Question 8 – Frequency of eligibility-related denials?

This measures how often denials are caused by basic coverage/eligibility errors.

Options:
• Rare (< 2% of claims) (score 2)
– Strong front-end processes.

• Occasional (2–7%) (score 1)
– Some gaps that can be improved.

• Frequent (> 7%) or no idea (score 0)
– Either high error rates or zero visibility; both are bad.

7. Section 3 – Claims Submission & Payment Posting

Goal: Ensure services are converted into clean claims quickly and payments are posted promptly.

7.1 Question 9 – Claim submission frequency?

How often they actually transmit claims to payers.

Options:
• Daily (or near-daily) (score 2)

– Best practice. Keeps cash moving.

• 2–3 times per week (score 1)
– Acceptable but can cause small cash delays.

• Weekly or less (score 0)
– Large batches and delays; errors accumulate.

7.2 Question 10 – Monitoring & fixing clearinghouse rejections?

Clearinghouse rejections are pre-denials. The payer never sees the claim until fixes are made.

Options:
• Reviewed and fixed same/next day (score 2)
– Very healthy. Minimal money stuck in limbo.

• Fixed within a week (score 1)
– Reasonable but slower.

• Not monitored / only when payer complains (score 0)
– Many claims never progress until someone chases them.

7.3 Question 11 – Speed of ERA/EOB posting into EMR?

ERAs/EOBs show exactly what was paid or denied. Posting them keeps A/R accurate.

Options:
• Within 48 hours (score 2)
– Almost real-time financial view.

• Within a week (score 1)
– Acceptable but slower.

• Longer / irregular / unknown (score 0)
– They don't really know how much money is outstanding.

7.4 Question 12 – Handling patient balances & statements?

After payer payments, remaining balances often belong to the patient.

Options:
• Systematic statements + collection workflow (score 2)
– Regular statements, reminders, and possibly payment plans.

• Occasional statements / on request (score 1)
– Money is collected reactively.

• Almost no structured patient collections (score 0)
– Significant percentage of revenue is never captured.

8. Section 4 – A/R & Denial Management

Goal: Understand how they manage outstanding balances and denied claims – the main sources of 'money on the table'.

8.1 Question 13 – Use of A/R aging reports (30/60/90+)?

A/R aging shows how long money has been outstanding.

Options:
• Reviewed weekly and actioned (score 2)
– They actively work down old balances.

• Reviewed monthly (score 1)
– Some discipline, slower reactions.

• Rarely / never / no report (score 0)
– No one is watching the bucket where many dollars hide.

8.2 Question 14 – Ownership of A/R follow-up & payer calls?

Consistent A/R work requires time and persistence.

Options:
• Dedicated person/team with clear role (score 2)
– A specific person or team chases unpaid claims.

• Shared between staff (score 1)
– Work happens only when someone has spare time.

• No one clearly responsible (score 0)
– Unpaid claims quietly age out until written off.

8.3 Question 15 – Denial tracking & root-cause analysis?

This shows whether they learn from denials or just keep resubmitting.

Options:
• Every denial logged with reason code & action (score 2)
– They can identify patterns and fix upstream issues.

• Some common denials tracked (score 1)
– Only a few major patterns are monitored.

• No structured denial tracking (score 0)
– Same issues repeat endlessly.

8.4 Question 16 – Standard process for correcting & resubmitting denials?

Once denied, do they have a clear playbook?

Options:
• Clear steps, timelines, and templates (score 2)
– Staff know how to fix each denial type.

• Handled case-by-case (score 1)
– Every denial is a new improvisation.

• No defined process (score 0)
– Many denials are never resolved properly.

9. Section 5 – Reporting, KPIs & Compliance

Goal: See whether they run RCM using data and basic compliance standards.

9.1 Question 17 – Monthly RCM reports reviewed?

Do they regularly sit down to look at billing and collections, not just bank balance?

Options:
• Yes, monthly with owner/manager (score 2)
– RCM is managed intentionally.

• Sometimes / ad hoc (score 1)
– Only when there's a problem.

• Almost never (score 0)
– Purely reactive management.

9.2 Question 18 – KPIs tracked (collections, denial rate, days in A/R, etc.)?

KPIs are the numbers that show RCM health.

Options:
• 3+ KPIs tracked consistently (score 2)
– Example KPIs: net collection rate, denial rate, days in A/R, no-show rate.

• 1–2 KPIs or inconsistent (score 1)
– Some metrics, but incomplete.

• No RCM KPIs tracked (score 0)
– They operate on gut feeling.

9.3 Question 19 – HIPAA-ready tools & basic staff training in place?

Compliance is both legal protection and a trust signal.

Options:

• Yes: secure tools + NDAs + training (score 2)
– Proper software, agreements, and staff awareness.

• Partially / informal (score 1)
– Some awareness, but inconsistent practices.

• No real compliance discipline (score 0)
– Risky from a data and payer perspective.

9.4 Question 20 – Data-driven improvement (fixing recurring issues)?

Do they change systems when they see recurring problems?

Options:

• Regularly improve process based on data (score 2)
– They adjust SOPs when they notice a new pattern.

• Occasionally adjust, not systematic (score 1)
– Some fixes but no real system.

• Mostly reactive / no structured improvement (score 0)
– Same problems show up monthly with no lasting fix.

10. Buttons & Results Area

10.1 Calculate Score button

When you click "Calculate score", the tool:

• Sums all answered questions.
• Calculates the percentage.
• Assigns a risk band (Red/Yellow/Green).
• Shows a progress bar and a talk track you can use live on the call.
• Highlights any unanswered questions in light red, with a note suggesting you complete them.

10.2 Download PDF summary button

Once a score is calculated, the "Download PDF summary" button becomes active.
The PDF includes:

• Date of the audit.
• Practice information (name, contact, clinic type, monthly sessions).
• Score summary (total, percentage, risk band).
• All questions, answers selected, and numeric scores.

Use cases:
• Email it to the provider after the call as a formal summary.
• Attach it to your internal notes or CRM so Velden has a permanent record.
If the pdf library cannot load, the tool falls back to opening a printable HTML version in a new tab.

10.3 Reset answers button

"Reset answers" clears all radio button selections and hides the results area. Use this between clinics so you start fresh.

11. Interpreting Scores & Talking to Providers

The tool shows a narrative talk track based on the score band:

• Red risk (0–50%) – Revenue at risk
– Message: Many RCM processes are manual, improvised, or missing. Cash is unpredictable, and a lot of work never turns into clean payment.

• Yellow risk (51–75%) – Leaky but fixable
– Message: Core pieces exist, but there are obvious leaks in intake, A/R, and denials. Velden can run a focused 60–90 day cleanup to stabilize collections without needing more patients.

• Green risk (76–100%) – Operationally strong
– Message: Base is solid; the value now is optimization, automation, and freeing the team from manual work.

Your job during the call is not to read this like a robot, but to adapt it:
• Use their actual score (e.g., "You're at 23/40 (57%)").
• Call out 2–3 specific weak spots from the questions.
• Connect those weak spots to Velden's concrete services (e.g., eligibility checks, denial management, A/R follow-up).

12. Recommended Flow for a Live Audit Call

1. Set context (2–3 minutes)
– Explain that you will walk through 20 quick questions about their RCM system.
– Emphasize: this is not to judge them, but to find where they can stop losing money.

2. Fill Practice Profile
– Ask for practice name, contact role, clinic type, and rough session volume.

3. Move section by section
– Use the section nav buttons to jump: Tech → Intake → Claims → A/R → Reporting.
– For each question, listen carefully and choose the answer that best matches reality.
– If you are confused, click the little "i" button next to the question to read the internal

explanation.

4. Calculate the score
– Click “Calculate score”.
– Scan the risk band and progress bar.
– Note any red flags (e.g., no ownership of A/R, no denial tracking, no eligibility checks).

5. Explain the result back to them
– Use the talk track text as a base.
– Focus on where Velden can help in the first 60–90 days.

6. Download and share PDF (after the call)
– Download the PDF summary.
– Email it with a short note summarizing 2–3 priorities and suggesting next steps (e.g., a proposal, pilot period, or deeper data pull).

13. Troubleshooting & Common Issues

• PDF library failed to load
– The tool will fall back to opening a printable HTML page in a new tab.
– From your browser, use “Print” → “Save as PDF” to save it.

• Button seems disabled
– The “Download PDF summary” button is disabled until you calculate a score at least once.

• Some questions are highlighted red
– This means they are unanswered. The tool can still calculate, but results are less accurate.

• Page feels long
– Use the section navigation buttons at the top to jump directly to any section.

14. Final Notes

This tool is only as valuable as how often you use it with real clinics. The real learning comes from:
• Running multiple clinics through the audit.
• Noticing which questions cause confusion.
• Tracking which patterns lead to good opportunities for Velden.

Over time, you can adjust wording, add examples, or even tweak scoring to better match what you see in the field. But the first step is simple: put 3 real behavioral clinics through this audit as soon as possible.