



COURSE TRANSCRIPT

Module title: Life Cycle of a Claim

Slide 1 Overview

Welcome to the Life Cycle of a Claim. In this course we'll review each stage of the claim's life cycle, and how they contribute to the health of the organization.

Slide 2 Overview: Why should we care about the Life Cycle of a Claim?

Why should we care about the life cycle of a claim? If a claim does not flow through the process of getting created, submitted, and paid properly, the hospital risks not getting paid.

The revenue cycle is the lifeblood of an organization, and the life cycle of a claim fits just within the revenue cycle.

Without regular monitoring and adjustments, errors and inefficiencies will damage the stability and success of the whole organization, possibly to the point of no return. Ensuring that the organization's revenue cycle, and therefore the life cycle of a claim is operating accurately and efficiently, will help reduce errors and prevent any future delays or denials in payment.

Slide 3 Overview: Impact on Healthcare

Throughout a claim's life cycle, various errors can occur. These errors often lead to denials. There are two types of denials that I want to tell you about. We have clinical denials and technical denials.

Clinical denials are where a claim fails to meet established coverage or the care does not meet the payer's medical necessity criteria. Technical, or administrative, denials occur when the claim does not have the required information or was filed incorrectly.

Different errors will create these denials. Errors negatively impact the hospitals and health systems in a number of ways. They often result in rework for business office staff, revenue losses, and patient dissatisfaction.

From here on out, I'm going to reference a metaphor that I'll use a few times throughout this presentation.

To set the stage for the revenue cycle and the claim's life cycle, let's think about McDonald's. Imagine what an order you placed looks like there. You're greeted at a desk where you give important information needed to get your order right (or your claim right). You pay for your order. If the wrong items are entered in the computer, you'll probably pay the wrong amount. Workers then put your order together in various stations. Someone's on fries, someone else is on burgers, someone else is on sodas. If anyone forgets an item or gives you the wrong item, or

gives a bigger item than you had asked and paid for, that McDonald's location is going to make less profit from your order. They'll have to remake something or eat the cost of the extra items that were mistakenly given away.

You get your order and you eat it. Your experience has been dependent on several factors: how you were treated, the ease of ordering, how quickly you received your order, the accurateness of it, and how it tasted. Maybe it was also impacted by some things that weren't directly utilized in the making of your order, like the cleanliness of the bathroom or whether they were out of ketchup packets.

Using this example, you can see how we've already covered staff rework, revenue loss, and patient satisfaction. Now let's jump into the life cycle in a hospital setting.

Slide 5 Topic 1: Life Cycle of a Claim

Here's what the life cycle areas look like in a hospital setting.

On the bottom left, we'll start with scheduling and registration. Then we'll move into documentation, coding, and charge capture, and end with billing and collections.

Slide 6 Topic 1: Life Cycle of a Claim

In registration, this is where patients are registered for their services. It can also be done over the phone. This is where patients provide their demographic and insurance information, those important critical data elements that are used to begin the medical record for the service and create the actual bill or claim.

Registration is in the front end of the revenue cycle in Patient Access. So at McDonald's, this is where you are placing your order with the employee.

Slide 7 Topic 1: Life Cycle of a Claim

We move into documentation, coding, and charge capture. This is the revenue-generating portion of the life cycle. Once the patient receives care from the doctors, nurses, lab technicians – all of those services are recorded in the patient's medical record. Each service has a special code and an associated charge or cost, just like a menu would at McDonald's, that is then added to the bill.

All of the services, as well as any equipment provided in the operating rooms, from cotton balls to bandaids, to using lasers and robotic surgery, it all gets charged, captured, and coded to a claim. This is the middle of the revenue cycle, also called mid-cycle.

In this mid-cycle area, this is where your burger, fries, and sodas would be compiled.

Slide 8 Topic 2: Front-End Functions

Lastly, we have our business office: the area in which the administrative tasks of billing, collecting, and posting payments all take place. Also happening here are follow-up and appeal efforts for any underpayments or denials that have come in. This is the back end of the revenue cycle.

So my McDonald's metaphor isn't totally accurate here since you've already paid for your burger up front. But this is generally where things are paid and any errors are resolved. So say your order was wrong and you want to talk to the manager. That's done in the business office.

Slide 9 Topic 2: Front-End Functions

Let's turn all of this into the revenue cycle now. There are three pieces: front, middle, and back. Starting with the front end: we have patient access, which includes scheduling, preregistration, and registration, and insurance verification, authorization and utilization management (or case management).

To quote Richard Davis, the CFO at George Washington University Hospital in Washington, DC: "Some of the things I have specifically focused on since I have been in this position of CFO are reducing the bad debt expense and improving the revenue cycle on the front end. I think a lot of hospitals focus a lot of their time on the back end of the revenue cycle, in collections. But I am a firm believer in obtaining high quality information up front. If we receive complete and proper information on the front end, from admitting to registration to clinical and case management, then the billing and collections staff have a much easier time getting out clean claims and collecting on them."

You can see that Richard has placed great importance on ensuring that his front end functions are properly functioning. This will have great impact on whether or not the hospital can receive reimbursement in the back end.

Slide 10 Topic 2: Front-End Functions

Let's now go stage by stage.

Patient Access is where services are scheduled. Patients are preregistered or registered for their services. Those critical data elements, like the patient's name, date of birth, Social Security number, and insurance information are collected and confirmed. Insurance coverage is verified. If anything goes wrong in this stage and incomplete or incorrect information is put into the system, that can lead to several things: inappropriate care and poor patient experience. Incorrect financial information can lead to a delay in payment, or a lack of insurance actually getting verified. Or not being able to reach the patient after they've already been discharged, which can lead to an inability to collect on patient liability amounts.

Slide 11 Topic 2: Front-End Functions

Schedulers and registrars begin the patient experience and the claim's life cycle. It is the first and most important step in successfully converting a patient's account into cash for the organization. Understanding all of the different issues behind an individual patient's insurance benefits, and the insurance cards (that are all so different) is crucial to a successful verification process.

Let's look at what errors might look like in terms of the cost to correct them. Say an employee in patient access is paid \$10 an hour, and works 6 hours on each claim to recoup funds or correct errors and that happens on 100 claims per month, that comes out to \$6000 worth of employee wages that are spent on fixing those errors. Multiply that by 12 months in the year – that's \$72,000 per year per employee to just correct errors that were created. What if that team has five people on it all doing the same thing: $\$72,000 \times 5$ is \$360,000 a year for an organization to lose, just because of correcting errors.

Slide 12 Topic 2: Front-End Functions

Next we'll move into authorization, or utilization management. This is also known as case management, or utilization review. These teams really have one foot in the revenue cycle administration and one in clinical quality. They work to help ensure that patients meet the qualifications for certain services and help review clinical appeals.

This is when a patient's primary insurance is notified of the patient's admission. This could happen during pre-services or when the patient arrives.

Insurance is contacted when services are scheduled in order to obtain pre-authorization or pre-certification. If that pre-authorization was not obtained prior to admission, the necessary auth for services is requested of the insurance at this time.

The medical necessity of services and the length of stay is evaluated by this team throughout the patient's whole stay to ensure the authorization accurately includes all of the information for the patient's care.

Slide 13 Topic 2: Front-End Functions

Many denials are the result of errors that come from the front end. There are so many different pieces of information that could be input incorrectly. The accuracy, completeness, and timeliness of front end processes can dramatically improve an organization's ability to submit a clean claim.

HBI research shows that about one quarter of 1% of a hospital's net patient revenue is attributed to authorization-related denials. I know that doesn't sound like a very big number,

but for an organization that averages about \$3.5 billion in net patient revenue per year, those auth-related denials represent over \$9 million dollars in lost revenue.

In order to mitigate front-end denials, it is important for patient access staff to record complete and accurate patient information, verify insurance eligibility and benefits in advance of the services whenever possible, obtain prior authorizations and pre-certifications required by payers in a timely manner, ensure medical necessity of the pre-authorization is supported by proper documentation, and collaborate with business office staff to identify and proactively address common errors leading to denials.

Slide 14 Topic 3: Mid-Cycle Functions

We'll move into the mid-cycle: our revenue-producing tasks. This includes clinical documentation and coding, charge capture, and charge description master maintenance.

Slide 15 Topic 3: Mid-Cycle Functions

In clinical documentation and coding: this is where nurses and doctors and technicians record all of the diagnoses, procedures, different supplies used, and drugs that were administered in a patient's medical record. This includes any special circumstances that would warrant additional explanation through coding modifiers. Each diagnosis and procedure and supply is documented and translated into a corresponding code. Those codes are placed on the UB-04 and later processed for payment by the insurance company.

One common illegal pitfall attributed to this department is called upcoding or downcoding. It's manipulating codes on a claim to reflect services that garner a higher reimbursement when those services didn't actually take place.

Slide 16 Topic 3: Mid-Cycle Functions

Let's talk about modifiers for a minute. Those two-digit codes are often a big oversight for coding departments that result in denials.

According to Medicare fiscal intermediary Noridian, modifiers can be two-digit numbers, two character modifiers, or alpha-numeric indicators. Modifiers provide additional information to payers to make sure that your provider gets paid correctly for the services rendered.

I've included a list of some common modifiers that you may be familiar with at the bottom of this slide.

In claims processing, many errors stem from the lack of necessary surgical modifiers. One that always sticks out would be modifier 50, a bilateral procedure. This is used when the same procedure is performed on both limbs. So for example, you're undergoing carpal tunnel surgery on both your right wrist and your left wrist. Instead of coding two surgical HCPCS codes, there would be one surgical code with a modifier of 50 to indicate that that surgery took place on both hands.

Slide 17 Topic 3: Mid-Cycle Functions

Just like with the front end, there are common pitfalls that an employee can fall into in clinical documentation and coding. Documentation and coding ultimately determine the supplies and procedures that an organization can bill. These mid-cycle functions impact whether a provider will receive the right reimbursement from insurance companies. They can also improve patient satisfaction.

According to industry reports, some of the most frequent denial reasons include coding edits and medical necessity issues, indicating the importance of careful coding and documentation improvement processes (or CDI).

Slide 18 Topic 3: Mid-Cycle Functions

An organization's charge description master requires great maintenance, which is why it has its own section here. Think of the CDM, the charge description master, as the facility's "menu". It's the list of all the supplies and services that the hospital bills, and it maps each charge to the appropriate revenue code and charge amount.

So let's go back to my McDonald's metaphor here for a minute. You order a Big Mac, a large fries, and a large Coke. Each of those items has its own code. The employee doesn't type in "large fries" each time; that employee punches in a code that represents large fries in their list of things that can actually be ordered. That code shows the item, the fries, and the price: \$2.00. But what if the system showed the wrong price because it wasn't updated with the last price increase from corporate? McDonald's will miss out on the extra reimbursement.

What about when new items are added: that code list is updated, the menu should be updated. But what if those items have already been added and now there's a duplicate? What if those duplicates have different prices? You can see how there can be a lot of confusion in maintaining the charge description master.

What about those ketchup packets that you get? Those are free, right? They aren't separately payable. They're considered to be included in the cost of everything else, kind of like certain supplies in the hospital, like Band-aids or drugs like Tylenol. Those things aren't separately payable either. They aren't specifically carved out in contracts to garner additional reimbursement. They're considered "already paid for" by including the cost in a per diem amount or whatever the reimbursement for the services provided would be.

Some common issues with CDM maintenance include the fact that it's really hard to maintain. There's thousands of codes. Some of those codes don't have a monetary value, and there's very little organized maintenance of these lists. There can be duplicate entries, or maybe a charge gets mapped to the wrong revenue code and the hospital is at risk for not receiving proper reimbursement for that item.

Slide 19 Topic 3: Mid-Cycle Functions

Let's dig deeper into the incorrect mapping of codes, or when codes have the wrong revenue code or the wrong charge associated with it on the CDM.

On the left side, you'll see the proper revenue code assignment for specific items like revenue code 278 for an implant, or 275 for a pacemaker. On the right, you'll see a sample CDM that has some incorrect mapping going on.

The service code in that table shows what an employee would type in, say at McDonald's when you order your large fries. Instead of ordering a large fries, of course, you're ordering a steel plate or a pacemaker.

The third line down, service code 1100113 is a pacemaker. You can see that the revenue code assigned is 272 and the price or the charge that will be added to the bill is \$10,000. Using our table on the left you can see that a pacemaker should be mapped to revenue code 275. Instead, 272, sterile supply, has been applied to the item. So what does that mean?

In a contract, the reimbursement rate for revenue code 275 could be 60% of charges.

The contracted reimbursement rate for revenue code 272, a sterile supply: there isn't one. It's not carved out. It's a "ketchup packet". It's not separately payable and is included in the per diem rate. So, if the pacemaker is incorrectly coded to revenue code 272, the organization is going to miss out on reimbursement of \$6000.

Slide 20 Topic 3: Mid-Cycle Functions

The last stage in the mid-cycle is charge capture. This is the stage in which all of the charges associated with the items and services which were documented in the medical records are added to the UB-04 with the help of the charge description master.

Those charges translate into revenue. Without accurate charges, a facility can't properly get reimbursed for the services rendered. Sometimes procedures or room charges or supplies are forgotten about or mistakenly left off the bill, resulting in the billing of a corrected claim with added late charges. Or worse, those charges never actually get billed and they never get paid for.

Slide 21 Topic 3: Mid-Cycle Functions

It's common that charges don't always make it to the bill. After all, a patient can be in several different departments during their stay. As a patient receives care, charges are added to the bill from each of those different departments that participate in the care plan.

For example, a patient can come in through the emergency room, head to radiology for labs, end up in the operating room, and then recover in the medical-surgical unit.

Slide 22 Topic 3: Mid-Cycle Functions

The mid-cycle is not without its problems, as you can see. There are so many different areas where something can go wrong. When assessing root causes of denials, HBI has found that coding and documentation account for about 10% of a standard organization's denials.

So how can we fix it? Revenue integrity staff can improve the whole claim process, or the life cycle, by ensuring that they understand the system and the processes, answer staff questions about a patient's care, conduct frequent reconciliations, regularly review the charge description master to ensure that all of the lines are coded correctly, and incorporate regulatory updates in a timely manner.

Physicians can help too, by improving the timeliness of submitting their charts, clearly documenting medical necessity, and perhaps also assisting in denial efforts by writing appeals or engaging in peer-to-peer reviews.

One thing to remember: the sooner charges are entered into the system, the sooner the claim can be coded, billed and (hopefully) paid.

Slide 23 Topic 4: Back-End Functions

Let's move into the back end functions now: the third piece of our revenue cycle. Back end includes back office tasks like claim generation, submission, contract management, follow-up, and payment posting.

Slide 24 Topic 4: Back-End Functions

We're now in the claim generation stage. The UB-04 now has all of the information it should need to be officially generated and pass through the system's claims scrubber to check for any errors, like conflicting HCPCS codes or any missing information. The scrubber will either allow the claim to go through to the next step – claim submission – or it will be flagged for additional work.

Slide 25 Topic 4: Back-End Functions

Assuming that the claim scrubber found no issues with the claim in the generation stage, the claim can now be submitted to the appropriate payer. This should have been determined through the patient access insurance verification step in the front end. The claim will be sent electronically or through paper mail, and within the timely filing limit set forth in the contract or by federal mandate.

Problems can happen when a claim is automatically rejected from an electronic clearinghouse due to improper coding or missing information that the claim scrubber missed, which does happen frequently. Maybe the paper claim can get lost in the mail or delivered to the wrong department. Or, perhaps, the claim wasn't billed within the timely filing limit and it was denied.

In order to help reduce denials, billers can do the following: reverify pre-authorization numbers or the authorization number, confirm clinical documentation is complete and supports medical necessity. Ensure that all required attachments, like invoices, are included if necessary. Make sure you are apprised of the payer's timely filing deadlines.

Slide 26 Topic 4: Back-End Functions

Contract Management is up next.

This is when the appropriate contract for the responsible payer and plan type, which should have been determined through that patient access insurance verification step, is loaded into the accounts profile to calculate the expected reimbursement.

The patient's particular plan will also play a role in determining how a claim should be processed and paid. Plan documents may require a review to ensure proper payment.

Patient accounting representatives or patient financial services representatives, or whatever the title is at your organization, should be well-versed in contract terminology, rates, and processing requirements and deadlines in order to ensure accuracy.

Problems come up when the wrong payer or the plan type was loaded to the account, and calculates an incorrect expected amount due.

Other issues come about when appeal staff do not have access to the contracts to research potential underpayment reasons.

Slide 27 Topic 4: Back-End Functions

Now that the claim has been submitted, we move to follow-up. Different status checks must be performed to ensure the claim is being processed correctly and timely by the insurance company.

Here are some things to think about.

Staff should always confirm receipt of the claim to ensure that it's actually in process. This could be an automatic confirmation that you get from the clearinghouse, or, if the claim was

submitted through the mail, a phone call should always be made to the insurance company just to make sure that they got it.

Ensure the payer has all of the necessary information to properly process the claim. This can mean including invoices, itemized bills, medical records that prove necessity, or authorizations if they are requested. And always confirm receipt of these materials one week after you send them in the mail.

A follow-up representative's role should also include comparing the received payment to the contract rates that were loaded during the contract management phase. If the payment doesn't equal the expected amount, contract the payer to figure out how the claim was processed, to be able to determine whether charges or services were denied, and verify that the correct contract was used to process the claim, and, of course, that it was uploaded properly to the account. Then that person should appeal the underpayment or the denial.

Slide 28 Topic 4: Back-End Functions

Follow-up is one of the most important parts of the revenue cycle and the life cycle of the claim. But it's also one of the most costly in both time and expense. After all, following up on a claim, or the proper payment of one, may require several different forms of contact. You may have to get on the phone, you may have to fax additional information, mail appeal letters, or log on to different payer websites to check statuses of a claim. Each form of contact takes a lot of time.

When I was doing account resolution and underpayment recovery, I was often on hold for well over 30 minutes before I actually got to speak to someone to get the information that I needed. Reviewing accounts to gain life cycle understanding, and compare the amount paid to the amount due, can take anywhere from 5 minutes for an easy claim to 60 minutes if a claim has been open for an extended amount of time, gone back and forth from different departments to fix errors, or has bounced around between different representatives within the insurance company. Trying to figure out the issue can take hours, and compiling documents for fax or writing appeals can take several minutes, or even days, depending on how many different departments need to be involved.

Follow-up tasks cost a lot of money, and pursuit of underpayments might not always be worth it. Patient accounting departments have got to take into account the amount of the underpayment, and how much time they think it might actually take to resolve a low balance account. If the wages paid for the time spent on that pursuit are greater than the underpayment itself: it's not worth pursuing and should be written off.

Slide 29 Topic 4: Back-End Functions

Our last stage in the back end: Payment Posting.

Finally, follow-up efforts have been exhausted and hopefully the claim has been paid. So now the payment and any necessary adjustments need to be posted to the account profile to move

the balance to zero or transfer the balance to the next responsible party, if one remains. That could be a secondary insurance, or perhaps a patient-for-patient liability.

Problems happen here in payment posting when the posting or the adjustment doesn't happen in a timely manner, leaving resolved accounts in the open A/R or delaying the billing of the next responsible party for months. Oftentimes the payment or the adjustment that's made in the system is incorrect, and sometimes the credit balances aren't attended to in a timely manner.

Slide 30 Topic 4: Back-End Functions

The back end of the revenue cycle is the organization's last line of defense against errors or issues that can impede claim resolution.

This is where all of the rework starts. Patient account representatives are responsible for finding the errors that took place and contacting the right departments to help get them fixed in a timely manner. Back end staff have to catch all of the errors that were made in every preceding stage. So what's the cost? Let's dig into another example.

Say there are 10 full time employees working in a denials or an underpayment team. One of those employees can work 15 accounts a day, so there are 150 accounts worked by that team every day. If one of those employees works 8 hours a day and earns \$10 an hour, let's turn that into team wages of \$800 a day. So if that team is responsible for correcting errors on 3600 accounts, that turns into 24 days worth of work. 24 days X \$800 in wages comes to \$19,200 spent just on correcting errors per team/per month.

Multiply that by 12 for the year, and you have \$230,000 spent every year just on trying to correct errors.

Slide 31 Topic 4: Back-End Functions

So how do we mitigate denials on the back end? Timeliness is key when conducting any of these back-end functions like claim submission and follow-up.

It's useful for billers and follow-up staff to be familiar with any timely filing deadlines or stipulations, and what required documentation needs to be submitted. All of this is outlined in the contract. HBI recommends as standard practice that follow-up representatives maintain an efficient work queue and confirm receipt of all of the submitted materials, whether that was electronic or via paper, within one week of submission, as well as calling the payer at least every 30 days to check the status of the claim in process.

Understanding basic contract language and how the claims expected reimbursement should be calculated will also help representatives understand whether or not the claim was actually paid correctly, or if an underpaid or denied claim should be appealed.

Don't forget: appeals are also subject to timely filing limits. So reviewing payments and tending to balances as soon as correspondence is received is critical in ensuring that proper payment comes in.

Understanding all of the different stages of the revenue cycle or the claim's life cycle can help a patient accounting representative and any other back-end staff make the proper request for assistance or obtain any additional information that needs to be sent to the payer in order to make sure that the claim can get processed correctly. They can't do all of the functions themselves. For example, if a claim needs to be re-coded, they'll need to task that claim back to the coding department to fix. So knowing where each department can help is critical.

Slide 33 Topic 5: Conclusion

So, let's recap. As you can see in the picture on the slide, the revenue cycle/the life cycle of the claim is a very complex process.

It includes lots of different staff across various departments that use different technology in order to get the claim out the door and paid properly by the insurance company.

The graphic on this slide provides examples for each of the more detailed stages of the revenue cycle and what could potentially go wrong. I encourage you to read through it.

Slide 34 Topic 5: Conclusion

So, in conclusion, the claim is the means to which an organization can get paid. The life cycle of the claim encompasses the entire revenue cycle, from the collection of patient information in patient access and proper documentation and coding conducted in the mid-cycle, all the way through to claim submission and follow-up with billing and collections.

Every staff member plays a key role, in not only the claim's success, but also the organization's financial well-being. Ultimately, if the life cycle of the claim is unhealthy, or if the revenue cycle is unhealthy, it can lead to rework, revenue loss, and patient dissatisfaction. Ensuring that the revenue cycle and the life cycle of the claim is healthy will help ensure the success of an organization.

Slide 35 Topic 5: Conclusion

Have any questions or want to learn more? Please reach out: email us at askhbi@teamdrg.com.