Revenue Cycle Management
Best Practices for Public Health Programs
February 2014
Erin Edelbrock
Program Manager, Cardea

About Cardea
Our Mission: Improve organizations’ abilities to deliver accessible, high quality, culturally proficient, and compassionate services to their clients.
• Training, organizational development, evaluation & research

STD-related Reproductive Health Training & Technical Assistance Center (STDRHTTAC) for Regions IV, IX and X.
Funded by a cooperative agreement by the Office of Population Affairs, within the Office of the Assistant Secretary for Health in collaboration with the Division of STD Prevention within the Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention.

Public Health Programs & Revenue

Revenue Cycle

Definition: all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue

Healthcare Financial Management Association

These functions can be categorized into three parts: Front-End, Intermediate and Back-End processes.

Revenue Cycle & Billing Foundations
Billing Foundation

- Third Party Payer Relationships
- Leadership & Staff Buy-in
- Information System Capacity
- Workforce Capacity
- Legislative/Policy Landscape

Adapted from Elements for Successful Immunization Billing Practice, New York State Dept of Health, June 2012

Revenue Cycle Management

IS NOT...
Only related to billing insurance; it includes collecting patient fees, managing program funds, etc.

IS...
the management of revenue cycle processes to allow for a steady stream of revenue

Revenue cycle management reflects an important truth—your services have value!

Best Practices: Front End Processes

**GOALS**
- Collect complete and accurate information
- Communicate financial policies to clients
- Collect first-party payments, as appropriate

Scheduling

**COLLECT** from the patient:
- Contact and demographic info
- Insurance info
- Reason for visit

**COMMUNICATE** to the patient:
- Agency financial policies and payment options
- Required documents for visit

Eligibility/Pre-Authorization

Using the information captured at scheduling...
- Contact insurance carrier to determine eligibility and seek pre-authorization, if applicable

- Reduces denials due to incorrect/missing information or insufficient coverage
- Reduces time at check-in

Reminders & Registration

Three opportunities to collect info from and communicate info to the patient:
- Initial scheduling
- Reminder call
- Registration/Check-in
**Registration/Check-in**

**COMMUNICATE to the patient:**
- Agency financial policies and payment options

**COLLECT from the patient:**
- Any updated contact, demographic, insurance info
- Copy of insurance card, as applicable
- Signed release forms (address confidentiality)
- Co-pays or other fees?

---

**Front End – Final Steps**

- Verify insurance eligibility
- Pre-populate encounter form/superbill

---

**Best Practices: Intermediate Processes**

**GOALS**
- Correctly and completely document all clinical care / capture all billable services
- Capture corresponding charges and codes

---

**Documentation & Coding**

**Paper**
- Encounter Form/Superbill
- Manual Charge Entry

**Clinical Care Documentation**
**Charge Capture**
**Coding Services**

**Electronic**
- Encounter Form/Superbill (EHR, Practice Management)

---

**Documentation & Coding**

Paper or electronic, either way…
- Documentation, charge capture and coding is a partnership between providers and billing staff
- Charges and codes must be supported by medical documentation

---

**Best Practices: Back End Processes**

**GOALS**
- Submit claims/send bills in an accurate and timely fashion
- Pursue all available avenues for reimbursement
- Minimize errors
Check Out
COMMUNICATE to the patient:
• Charges and account details, including the patient’s obligation

COLLECT from the patient:
• Payment, as appropriate (enter immediately)
• Commitment to a payment plan, as appropriate

Claims Submission
Review and correct claims
• Codes and charges, patient and provider info
• In-house v. Clearinghouse

Timely submission (know your payer’s guidelines)

Remittance Advice and Payment Posting
Remittance advice: information sent to a provider explaining how payments, adjustments or denials were applied

Paid? Congratulations! Post payment to the appropriate account as soon as possible
Partially paid or denied? Don’t give up – follow-up!

Denials Management
• Denials for claim errors; often easily corrected → modify and resubmit
• Denials due to payer error → appeal
• Denials due to lack of coverage for the patient or the service, unpaid deductible/co-ins, etc. → bill secondary payers or patient, as appropriate

Patient Billing
Check payer and program rules (including Medicare, Medicaid, Title X) around balance billing to patients
If balance billing allowed…
• Have written policies and procedures and train staff on how to discuss charges and balances
• Send initial statement as close to visit as possible; follow up with regular, detailed statements
• Provide multiple payment options

Quality Improvement
Quality Improvement
• A philosophy/approach
• Driven by staff & clients
• Focuses on systems and processes; builds on strengths
• Assumes that the system, not the individual is the root cause of most problems

Quality Assurance
• A specific activity
• Driven by management
• Focus on policies & procedures; tasks & compliance checks
• Includes performance evaluations
• Seeks to identify problems and make corrections
A Quality Improvement Plan

• Leadership Involvement — Mission, Goals, Resources
• Team Empowerment—Responsibilities, Timeline
• Customer Focus
• Data Collection—tools; defined indicators, benchmarks
• Process—Plan, Do, Check, Act; continuous
• Celebrate success!


What are your agency’s strengths and areas for improvement?

<table>
<thead>
<tr>
<th>Front End</th>
<th>Intermediate</th>
<th>Back End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduling</td>
<td>Clinical Care</td>
<td>Claims Submission</td>
</tr>
<tr>
<td>Registration</td>
<td>Documentation</td>
<td>Claims Follow-up</td>
</tr>
<tr>
<td>Eligibility Verification</td>
<td>Charge Capture</td>
<td>Denials management</td>
</tr>
<tr>
<td>Fee Determination</td>
<td>Coding Services</td>
<td>Payment posting</td>
</tr>
<tr>
<td>Patient communication</td>
<td></td>
<td>Balance billing</td>
</tr>
</tbody>
</table>

Quality Improvement

Resources from Cardea

• Case studies of public health programs that are currently billing
• Webinars and other online learning tools
• An online learning community to help you connect with peers and access resources
• Customized training and technical assistance

Contact Information

Erin Edelbrock
Program Manager
erin@cardeaservices.org
206.447.9538
www.cardeaservices.org
@CardeaServices