UAMS MEDICAL CENTER
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

# Revenue Cycle Management

2007 Edition

## INTRODUCTION

Welcome! The program is facilitated by the Revenue Integrity Specialist Team (RIST). Our mission is to conduct timely and consistent reviews of patient registrations, provide feedback, education and training, and serve as a resource for access personnel at UAMS. Our main telephone is 501-686-5102. Visit us on the web at www.uams.edu/rist for direct contact information and helpful resources. *Enjoy the class!*

### OBJECTIVES DAY 1

- Define the Revenue Cycle and identify your role in it
- List the 3 functions of patient access services
- Define the role of the medical record
- Correctly interpret key identifiers on a patient label
- Demonstrate proper patient search and name entry procedures
- Give an example of PHI
- Name the Anti-Dumping act
- Give 2 advantages of participating in a accreditation survey
- Name two examples of negative body language
- Give two examples of a living will
- Explain the differences between an HMO, PPO and POS plan
- Identify the purpose of pre-certifications and prior-authorizations
- Describe the function(s) of a plan code
- Briefly describe COBRA coverage

### OBJECTIVES DAY 2

- Define a Medigap plan
- Differentiate between BCBS products
- Give 2 examples of a TPL
- Identify who is eligible for Black Lung coverage and when to bill it
- List advantages of Pre-registration and insurance verification
- Name the 2 billing offices at UAMS
- Identify registration requirements for Medicare, Medicaid and Tricare
- Differentiate between insurance products
- Bill plans in the correct order

**OBJECTIVES DAY 3**

- Online Resources
- IMA Web University
- Pre-Registration
- Insurance Verification
- VoiCert
- Eligibility Assistant
- VisionShare
- Verification Assistant - Address Check
- PHS-RWS Workflows

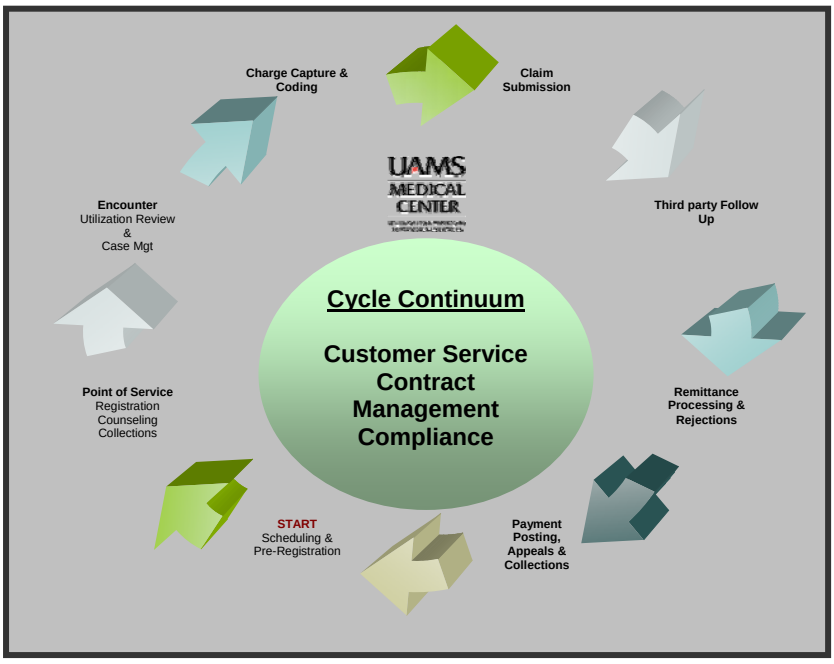
# CHAPTER 1: THE REVENUE CYCLE


**Covered in this chapter:**

- ☑ Revenue Cycle
- ☑ Terminology

The Healthcare Financial Management Association (HFMA) defines revenue cycle as **"All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue."** In other words, it is a term that includes the entire life of a patient account from creation to payment; the steps that must be taken to be compensated for services rendered. "The health care revenue cycle is dynamic and changes over time. As the diagram shows, revenue cycle processes flow into and affect one another. When processes are executed correctly, the cycle performs predictably. However, problems early in the cycle can have significant ripple effects. The further an error travels through the revenue cycle, the more costly revenue recovery becomes (Moffatt, 2005)." Note that patient access services begin the revenue cycle. Establishing an accurate and complete medical record is essential to timely and accurate billing as well as patient safety and patient satisfaction.

*Each point in the revenue cycle represents a "moment of truth."*



**Revenue Cycle Terms Review**

| | | |
|---|---|---|
| A Registration | D. Charge Capture | G. Claims processing |
| B. Remittance processing | E. Third Party Follow-up | H. Pre-registration |
| C. Patient Collections | F. Utilization Review | |

1. _____ Pursue collections from insurers after the initial claim has been filed
2. _____Evaluation of the necessity, appropriateness, and efficiency of the use of medical services and facilities, which includes regular reviews of admissions, length of stay, services performed, and referrals.
3. _____Collecting patient balances, making payment arrangements
4. _____Collection of a comprehensive set of data elements required in establishing a Medical Record Number and satisfying regulatory, financial and clinical requirements.
5. _____Documented services are manually or electronically translated into billable fees
6. _____Determining variances from expected payments
7. _____Posting or applying payments / adjustments to the appropriate accounts, including rejections
8. _____Collection of all registration information, including eligibility, benefits and authorizations, prior to the patient's arrival for inpatient or outpatient procedures

# CHAPTER 2: PATIENT ACCESS SERVICES

**Covered in this chapter:**

- ☑ The role and impact of patient access services
- ☑ NAHAM

**Patient access services function to**

1. **Gather Permanent Identification of the Patient**
   - Medical Record Number
   - Update Demographic Information
   - Scan Insurance Cards/Photo
   - Determine Primary Insurance


2. **Provide Information to the Patient/Family**
   - Advanced Directives
   - Patient Bill of Rights
   - Patient Right to Privacy under HIPAA
   - Important Message from Medicare/Tri Care
   - Applications for Financial Assistance

3. **Determine Special Needs of the Patient**
   - Admitting diagnosis may indicate need for Special rooms such as Reverse Air Flow (RAF) or Positive Air Flow (PAF), specialty bed or equipment
   - Language barrier
   - Spiritual advisor
   - Wheelchair, Blanket or other comfort items

**Healthcare access is an integration of services that:**

- Allows for accurate and completed data collection and satisfaction of prerequisites
- Completes appropriate follow up to assure data integrity
- Integrates the data collection necessary for financial integrity, clinical care, and discharge planning processes and continually monitors for complete and accurate data
- Provides and assure accuracy in statistical reporting
- Allows for the management of confidential communication of pertinent data throughout the continuum of care to eliminate repetitive questioning
- Encourages personalized care and service to patients, family, visitors, physicians, and other providers in the continuum of care
- Values and respects all persons who support the provision of healthcare service while empowering and motivating everyone to address customer needs

The National Association of Healthcare Access Management is the only national organization of its kind dedicated to issues concerning access management. This organization offers many educational and networking opportunities. Visit them at www.naham.org. They offer credentialing and educational opportunities for access staff throughout the year. Please ask a member of the RIST for more information if you are interested!

## CHAPTER 3: REGULATORY AGENCIES AND ACTS

**Covered in this chapter:**

- ☑ HIPAA
- ☑ EMTALA
- ☑ JCAHO

**The Health Insurance Portability and Accountability Act (HIPAA)** A legislative act passed in 1996 that protects health insurance coverage for workers who change or lose their job and establishes standards for the privacy and security of individually identifiable health information. **Title II Administrative Simplification** addresses issues of privacy requiring that provide standards for privacy.

**Protected Health Information (PHI) is** that which identifies the individual. It includes demographic information and relates to the past, present or future physical or mental health or condition of the individual; to the provision of health care services to the individual; or to the past, present, or future payment for the provision of health care services to an individual. PHI includes information that is recorded or transmitted, in any form (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer. Refer to UAMS policies and procedures, and HIPAA HINTS for practical advice on how to comply with this law when performing patient access functions: http://hipaa.uams.edu/HIPAA%20Hints_031506.pdf

### Accountability

HIPAA has established penalties for the misuse of protected health information. They include civil penalties of $100 per violation, up to $25,000 per year and criminal penalties. The criminal penalties include $50,000 and one year in prison. Under “False Pretenses”, the fine is up to $100,000 and five years in prison. Crimes with the intent to sell or use PHI for commercial advantage carry a penalty of $250,000 and ten years in prison.


**The Emergency Medical Treatment and Active Labor Act**

The Emergency Medical Treatment and Active Labor Act (EMTALA) passed in April 1986 as part of COBRA to prevent hospitals from "dumping" patients. **"Dumping" refers to hospitals denying emergency care or transferring of patients based on a person's ability to pay or the type of insurance coverage that person has.**

A revision was added to the act in 1998 which states that in an emergency situation, hospitals cannot make a call to insurance companies regarding insurance verification or pre-authorization prior to stabilizing the patient (in other words, the medical screening exam cannot be delayed for economic determination). In 2000, new regulations were issued for the Outpatient Prospective Payment System (OPPS). These new regulations expanded EMTALA considerably. The OPPS requires hospitals to provide emergency response capabilities (besides 911) for accidents, injuries, or patient presentations on the hospital campus. The defining zone for emergency response is **250 yards**. This includes anything considered hospital property such as parking lots, sidewalks, etc. Violations can be extremely costly. Calls to insurance companies or employers, or handing the telephone to a patient to contact the insurance company or employer, before the medical screening is rendered, have all resulted in citations for COBRA violations. Calls may be made after the patient is stabilized.


**The Joint Commission for Accreditation of Healthcare Organizations** is a **not for profit organization** that accredits over 18,000 hospitals and other healthcare organizations. The Joint Commission sets standards that address the hospital's level of performance in key functional areas such as patient rights. To earn and maintain accreditation an organization must undergo an on-site survey by a Joint Commission survey team.

**The survey is a "voluntary" process and an accreditation from JCAHO benefits providers by:**

- Enhancing community confidence, providing a report card for the public
- Offering an objective evaluation of performance
- Stimulating quality improvement efforts
- Aiding in professional staff recruitment
- Providing staff education tools
- Often fulfilling state licensure requirements
- Favorably influencing liability insurance premiums
- Favorably influencing managed care contracts
- A JCAHO accreditation also serves as an alternative to a state survey, which is required to maintain status as a Medicare provider.

**Case Study #1**

A patient arrives in the Emergency Department (ED) for treatment and states, “I have Blue Cross Blue Shield and I don’t know if UAMS is covered.”

Can access personnel call the insurance to verify the benefits? _____

What regulatory agency/act provides the answer? _____

**Case Study # 2**

Mr. Jones is a patient seen often in the outpatient clinic. The registration specialist needs to see Mr. Jones again to verify some demographic information. She calls out in the crowded waiting room: “Mr. Jones, please come to the front desk. I think I have your Social Security # wrong- is it 433-39-2107?” Mr. Jones slowly gets up and approaches the desk … There is another patient at the desk that moves to the side to allow him to get in to see the Registration Specialist. The Registration Specialist does the following: "Here, let me turn the computer screen so you can see if this information is right.”

What is wrong with this scenario? _____

What regulatory agency/act comes to mind? _____

**Case Study # 3**

A Supervisor asks a billing specialist to make sure that she completes her performance appraisal in a timely manner and to complete her age specific competencies. The supervisor states: “You know JCAHO is coming in a few months and they’ll look at this.”

Who is JCAHO?

_____

Why would JCAHO care about employee evaluation information?