Revenue Recovery
Are You Capturing All You Can?

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Everyone’s Favorite Topic

♦ Who doesn’t love hearing the words “Revenue”
  – Especially when beating expectations
    • Revenue is always good
    • And when things are good, things are good
♦ In contrast, who doesn’t hate hearing the words “We Need More Revenue”
  – It implies pressure
    • In healthcare, this could mean “something is broken”
    • And when things are bad, things are bad
Everyone’s Favorite Topic

♦ So, what can you do when you “Need More Revenue?”
This is What We’ll Discuss Today….

- Revenue Recovery opportunities in the real world
- Big wins vs. small wins – Back to Basics
- Share “Real World” examples
- Provide solutions
What does this Mean to You

♦ Revenue Recovery:
  “Identify and properly capture and correctly collect for services performed for what is rightfully yours”

♦ Why is such a simple concept so challenging
Defining Revenue Recovery vs. Enhancement

Retrospective

Prospective
The term “Revenue Recovery” has emerged and is commonplace among healthcare providers today; however

– What does it really mean
– What functions are included under the umbrella of Revenue Recovery
– Lastly, how is Revenue Recovery performance objectively measured
The Revenue Recovery Evolution

- Many functions historically performed in a Business Office, Coding Department, Finance Department, Compliance Department, Managed Care Department, and other areas are being consolidated to achieve outcomes:
  - Avoid revenue leakage to begin with
  - Identify revenue recovery opportunities
  - Ensure billing compliance
  - Create operation synergy
Sounds Simple, What Could Go Wrong

♦ For starters, there is no “once size fits all” or “best practice” model
♦ The term Revenue Recovery is very subjective and means different things to different providers
♦ What works for one provider may not work for another
♦ Also, the challenges are endless
  – Internal reorganization
  – Recruiting subject matter experts
  – Turnover of key positions
  – Clearly defined roles and responsibilities in a changing environment
  – Lack of policies and procedures
  – Lack of KPI’s
In simple terms this translates to:

“A system or process breakdown that prevents a hospital from getting paid accurately or timely”

3 to 5 percent net revenue is the typically left on the table

For the state of Texas acute care providers, there is approximately $50M to $110M
This brings us to the Million Dollar Question

Why do we have some many revenue challenges?
Some Pretty Good Reasons

♦ A dynamic healthcare environment
♦ Regulatory changes
  – What is going to happen
♦ More responsibility at the patient level
♦ Oldies but goodies
  – People
  – Process
  – Technology
Big Wins vs. Small Wins

♦ Revenue Cycle transformation projects are a significant undertaking and take a long time
♦ Revenue Recovery projects are smaller in nature and have a quicker turnaround time
♦ “Back to Basics” in blocking and tackling
What’s The Bottom Line

“You don’t know what you don’t know!”

♦ No one person knows everything, the healthcare landscape is simply too complex
♦ Revenue Recovery requires “subject matter expertise” in patient access, case management, charge capture, charge description master, coding, compliance, patient financial services, managed care, reimbursement, and finance
♦ Coordination between all of these subject matter experts is essential to successful revenue recovery initiatives
Let’s Talk More About Technology…

- Hospitals rely on information systems to link the Revenue Cycle Departments and electronically push information flow from department to department.
- Information systems are not perfect and often have limitations. Additionally, these systems are only as good as the people who program them.
- Are your processes built around systems, or are systems built around your processes?
- Do you rely too heavily on technology?
Here’s the Bottom Line: Systems Don’t Solve Problems without People

♦ Our reliance on computer technology is one of the major underlying reasons why revenue recovery opportunities exist
♦ Over the last decade we have focused more on technology with a diminishing need for people
♦ Computer automation has given us a false sense of security
♦ Personal interaction has decreased
♦ Critical thinking and deductive reasoning are less valued
Revenue Recovery: Real World Examples

JUST GO TO www.criticalthinking.com AND CLICK ON "ANSWERS"!
Revenue Recovery Opportunities

- Transfer DRG
- IME/GME Medicare Advantage
- Medicare Bad Debt
- Disproportionate Share
- Other Areas to Consider
Transfer DRG

♦ History of TDRGS
  – October 1, 1998 – 10 DRGs were ‘classified’ as Transfer DRGs
  – October 1, 2003 – Expanded to 30 Transfer DRGs
  – October 1, 2005 – Expanded to 182 Transfer DRGs
  – October 1, 2006 – Expanded to 190 Transfer DRGs
  – October 1, 2007 – Expanded to 273 Transfer DRGs
  – October 1, 2009 – Expanded to 275 Transfer DRGs
  – October 1, 2015 – Expanded to 280 Transfer DRGs

No Significant changes since 2009
Transfer DRG

- What is a Transfer DRG
- What happens when a hospital codes a discharge as home but post-acute care services are received
- What happens when a hospital codes a discharge to post-acute care but the services are not received
Transfer DRG

♦ How to Capture the Revenue
  – Perform reviews in-house
  – Hire outside assistance
  – A combination of both

♦ What to Consider When Reviewing
  – Time lag between dropping a claim and researching a claim
  – Timely filing of adjustments
  – Contacting MACs
  – Contacting post-acute care providers
  – Reviewing medical records

♦ Can Technology Solve this Issue
Compliance Issues to Consider

♦ Expired SNF benefit days
♦ Beware of software solutions
♦ RAC adjustments
♦ The OIG Work Plan
  – Does the CMS edit capture everything
  – Utilization of Condition Code 42
  – Utilization of Condition Code 43
Discharges to Home

♦ Does the CMS edit catch it all
♦ What can be done
IME/GME Shadow Billing

♦ Synonymous for “No Pay” or “Information Only” claim
♦ Claim is submitted to the Medicare Administrative Contractor (MAC) for Medicare Part A services provided to Medicare Advantage beneficiaries for the purpose of receiving supplemental payments
  – Indirect Medical Education (IME)
  – Graduate Medical Education (GME)
IME/GME Shadow Billing

- Identify claims that were not submitted to Medicare for Medicare Advantage patients
- Areas of Focus
  - Claims that should have been Shadow Billed, but weren’t
  - Claims where information was missing
  - Liability claims
  - Misclassified accounts
- Medicare Advantage products are continuing to gain favor – more opportunity
Medicare Bad Debt

- What is Medicare Bad Debt
  - Process to analyze a hospital’s Medicare deductible and coinsurance amounts to determine unidentified MBD reimbursement, a component of settlement in a hospital’s annual Medicare cost report
  - End Goal – identifying additional MBD
  - Perform complete reconciliation of Medicare deductible/coinsurance between detailed PS&R and hospital patient financial system
    - Categorize patient accounts into crossover/dual eligible, self-pay, charity care and deceased/bankrupt
    - Comparison to cost report MBD claimed listing
    - Detail testing to validate supporting documentation
Medicare Bad Debt

- Provide documentation to support Medicare audit
  - Remittance advices
  - Collection agency inventories
  - Charity care applications
  - Proof of deceased/bankruptcy
- Amend or reopen cost reports to claim additional MBD
- Retrospective
Disproportionate Share

♦ What is Disproportionate Share
  – Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals
  – Identify and capture DSH eligible days
    • Obtain Medicaid eligibility matches in-state and out-of-state
    • Determination of includable DSH eligible Medicaid “aid” codes
    • Exclude non-acute care patients and Medicare Part A eligible
    • Perform secondary review of patients registered as Medicaid with no Medicaid eligibility match
Disproportionate Share

- Provide documentation to support Medicare audit
  - Rerun data through match process to update results
  - Proof of Medicaid eligibility
  - Proof of inpatient status
- Amend or reopen cost reports to claim additional DSH eligible days
Regardless of where your Revenue Recovery functions are performed, or what model is selected (centralized, decentralized, etc.), there are several critical success factors to ensure success. Here’s a road map:

- Ensure policies and procedures exist and reflect industry standards
- Ensure operational processes reflect existing policies
- Ensure job descriptions exist and define scope of work
Where Do I Begin

– Determine potential “hand off” issues between departments, such as how the information is shared, corrected, and identify root cause
– Determine if internal resources exist to perform functions or if external resources are needed
– Determine how resources should be governed
Where Do I Begin

- Determine the level of standardization to maximize efficiency
- Establish internal auditing protocols to ensure accuracy
- Provide training and education to all service areas as needed based on audit results
- Develop key performance indicators (KPI’s)
Revenue Recovery Solutions Summary

- Ensure policies and procedures exist for key Revenue Recovery functional areas
- Ensure job descriptions exist and accurately reflect scope of work
- Ensure monitoring tools are performance focused
- Form a revenue recovery committee or task force of key leaders that meets regularly
- Cross train “intelligent” resources
- Have a training and education program to fix underlying root causes
- Do not solely rely on systems, instead build systems to support your processes
Other Opportunities

- Once you have mastered Revenue Recovery or Retrospective opportunities, you can focus on some enhancement or prospective opportunities
Questions
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