

Your Challenge

Healthcare providers across the country continue to face obstacles in establishing and maintaining acceptable operating margins. Critical operational tasks can become increasingly difficult in the absence of a facility's patient account director. **What are you going to do?**

Our Service

Whether you expect to fill this critical position within weeks or months, Revenue Cycle Solutions, LLC is the answer. Our many years of business office experience means we can efficiently maintain and improve the performance of your patient accounts department while you search for a permanent manager.

Our experienced management professionals are on-site within two weeks of notification to manage department personnel in any or all of the following areas:

- ✧ Admissions / Registration
- ✧ Insurance Verification
- ✧ Charge Processing
- ✧ Billing
- ✧ Follow-up / Collections
- ✧ Payment Posting
- ✧ Bad Debt / Agency Management

RCS establishes baseline measurements of a provider's financial and revenue cycle performance through the creation of applicable benchmarks. Our on-site management team moves quickly to evaluate and assign staff to ensure optimal results during our interim management period.

Recommendations for improving operational efficiencies are provided to assist management in the proper identification, implementation and tracking of improvement efforts.

Our Approach

- In-depth discussion with senior management to ascertain concerns and discuss program objectives
- Interim management plan developed and implemented
- Essential report information identified and validated with appropriate hospital personnel
- Pertinent information extracted and used to create indices and benchmarks including:
 - ❧ Aging Analysis by Payer
 - ❧ Unbilled Accounts Receivable
 - ❧ Late Charge Postings by Service Area
 - ❧ Service to Billing Timeframes
 - ❧ Billing to Follow-Up Timeframes
 - ❧ Service to Collection Timeframes
 - ❧ Claim Denial Volumes/ Amounts /Types
 - ❧ Bad Debt / Bad Debt Recovery Levels
 - ❧ Cash Collection to Net Revenue Ratio
 - ❧ Cost to Collect
- Key financial indicators validated and measured for optimal performance
- Customized plan drafted to address adequacy of existing staff, prioritization of daily tasks, and implementation and monitoring of department goals

Your Benefits

Our experienced management professionals positively impact cash flow and staff performance. RCS takes the time to thoroughly understand all areas of concern and address any related questions before work is initiated. Results include:

- ❧ Increased accuracy with all account information
- ❧ Timely verification and processing of pertinent account information
- ❧ Improved efficiency with charge postings and coding
- ❧ Shortened timeframe from discharge to final bill
- ❧ Reduced volume of claim denials
- ❧ Increased cash flow
- ❧ Reduced AR days outstanding
- ❧ Lower bad debt and charity write-offs

Your Challenge

In today's environment, the average hospital signs numerous contracts with managed care organizations and insurers. Many of these contracts contain provisions that hamper a hospital's ability to obtain adequate reimbursement, unduly restrict billing and appeal timeframes, allow unnamed, non-contracting organizations to discount reimbursements to the hospital, and expose the hospital to unnecessary liability and loss.

Most hospitals do not have the time or resources to review these contracts in detail, compile and analyze meaningful performance data, and monitor their financial impact. This could cause significant losses due to untimely claim submissions and appeals, increased work for staff and automatic renewal of unprofitable contracts. **How can you better manage this important area of your business?**

Our Service

RCS will gather, review and summarize core contract and performance information for each payer and insurance product. The contract information will be prepared and presented in a summary matrix format for your quick reference, and a separate, more comprehensive summary will be prepared for each payer. RCS will update all pertinent contract information quarterly to ensure all key departments are working with the latest information. RCS can also provide expert consultation about contract modifications, bargaining strategies and other contract issues. In fact, because of our exposure to a wide variety of contractual relationships, many of our clients take advantage of our all-inclusive negotiation services.

Core contract information includes:

- ✧ Payer contact name, address, telephone and email address
- ✧ Term of contract
- ✧ Rate methodologies by service w/ date of last revision
- ✧ Time limit to submit initial claim
- ✧ Time limit to make payment determination
- ✧ Time limit to appeal denied claim
- ✧ Network affiliates and other covered entities

Performance information includes:

- ✧ Average insurance payment percentage relative to gross charge
- ✧ Average lag time from claim submission to receipt of payment
- ✧ Average patient responsibility per paid claim
- ✧ Average volume and charge amount of claims denied
- ✧ Denial breakdown by category
- ✧ Key considerations for improved performance and profitability

Our Approach

- 🌀 Gather and review all original contracts and applicable addenda
- 🌀 Confirm and update payer contact information
- 🌀 Work with payers to obtain key documents and validate accuracy
- 🌀 Extract and display rate methodologies in an easy-to-read format
- 🌀 Audit core sample of claims for each payer to gauge performance indicators

Your Benefits

RCS will provide current and complete rate summaries and reports of key performance indicators for every active managed-care contract. In addition to receiving timely advice and consultation about these contracts from an experienced and objective outside source, you will be able to:

- 🌀 Understand your managed care contracts and their financial impact on your hospital
- 🌀 Educate your staff and modify your financial systems to capture all negotiated reimbursements
- 🌀 Make intelligent decisions about contract renewals and modifications
- 🌀 Respond intelligently and promptly to problems and issues concerning your managed care contracts

Your Challenge

Maintaining the status quo can be costly. As health care operating margins shrink, you need to find efficient and innovative ways to capture and collect revenues. If your staff and procedures have been on autopilot too long, you're probably leaving money on the table. **But how do you bring about changes that don't disrupt your operations, or alienate your staff?**

Our Service

RCS can help you analyze your current revenue cycle operations and focus on ways to improve revenue capture and collection. Revenue problems rarely stem from a single source; they are most often the result of deficiencies in education, training, staffing levels, workflow, or poorly implemented computer software. Each deficiency must be addressed as part of a coordinated solution to obtain real improvement.

As the first step of our **RC Review**, we establish baseline measurements of a provider's financial and revenue cycle performance and create applicable benchmarks. We'll send experienced Revenue Cycle consultants on-site to gather the information necessary to provide you with recommendations in the following areas:

- 🌀 Scheduling / Pre-registration
- 🌀 Admissions / Registration
- 🌀 Insurance Verification
- 🌀 Charge Processing
- 🌀 Billing
- 🌀 Follow up / Collections
- 🌀 Payment Posting
- 🌀 Bad Debt / Agency Management

We will complete a detailed operational assessment of the revenue cycle to identify opportunities for improvement, while also focusing on operational and documentary compliance with HIPAA privacy and security standards. We'll then provide a written work plan containing an assessment of your overall revenue operations, and recommendations for the creation, implementation and monitoring of workable solutions.

Our Approach

- In-depth discussions with senior management to understand concerns and establish program objectives
- Customized review of operations, including interviews of key management personnel
- Hands-on participation by senior RCS staff
- Validation of key information by appropriate hospital personnel
- Creation of applicable indices and benchmarks including:
 - Aging Analysis by Payer
 - Unbilled Accounts Receivable
 - Late Charge Postings by Service Area
 - Service to Billing Timeframes
 - Billing to Follow-Up Timeframes
 - Service to Collection Timeframes
 - Claim Denial Volumes/ Amounts /Types
 - Bad Debt / Bad Debt Recovery Levels
 - Credit Balance Levels
 - Cash Collection to Net Revenue Ratio
 - Cost to Collect
- Detailed analysis and documentation of all significant revenue cycle processes, including issues relating to compliance with HIPAA privacy regulations
- Timely completion of work, typically completed four to six weeks after obtaining all pertinent information
- Detailed management report

Your Benefits

Typical improvements include:

- Increased accuracy of account information
- Timely verification and processing of pertinent account information
- Improved timeliness and accuracy of charge postings
- Shortened timeframe from discharge to final bill
- Reduced volume of claim denials
- Reduced AR days outstanding
- Lower bad debt and charity write-offs
- Increased cash flow

Your Challenge

Small and mid-sized hospitals face the same complex billing and reimbursement issues as larger facilities. Their business office and patient account managers must know how to efficiently manage and coordinate communications among the hospital's billers, clinical services, medical records department, finance department and outside vendors, third party payers and patients.

If your hospital is typical, you know the difficulty of attracting, recruiting and retaining skilled managers who can handle the challenge. This may be due to your size, geographic location or limited budget. As a result, you may be struggling without a real manager, tolerating an ineffective one, or paying more than you can afford. **Are these the only solutions?**

Our Service

Through its focus on the unique challenges facing small and mid-size hospitals, RCS has developed a service that provides quality patient account management and access to additional expert resources for less than the average cost of an experienced full-time manager. Mentoring of key personnel has proven to be one of the most essential benefits of this process.

The **Virtual Manager** begins with an intensive on-site analysis and organization of a facility's patient accounting department and staff. RCS works with staff and management to set goals, establish policies and procedures, and develop protocols for ongoing communications between RCS and the patient accounting department.

RCS then begins remote management of the patient accounting department and routine monitoring of performance standards. Through remote and on-site communications customized to the needs of the facility, RCS maintains contact with patient accounting staff, hospital departments and management, third-party payers, and vendors.

Our Approach

Phase I: On-site Review

- Meet with key management to gain an understanding of primary concerns and objectives
- Review departmental procedures and revise/supplement as necessary
- Observe department staff
- Identify lead staff to perform specific management tasks as directed by RCS
- Realign existing staff to optimize department performance
- Establish and implement short-term (3-6 months) performance standards
- Create reference files of third-party payer contracts, policies, procedures, outside vendors, etc.
- Establish remote access link between RCS and hospital's patient accounting system
- Set up dedicated telephone line for automatic rollover to RCS
- Create, review and finalize Operations Plan with help of senior management and staff

Phase II: Active Virtual Management

- Remotely monitor patient account data and system financial reports
- Monitor key financial reports
- Monitor key performance reports with emphasis on cash flows
- Communicate with third-party payers on contract and reimbursement matters through Internet access and other forms of communication
- Communicate with ancillary service departments as needed
- Interpret regulatory updates and communicate to staff as needed
- Conduct regular conference calls with key staff to review department performance and status of management tasks assigned
- Provide key staff and senior management with regular updates of department's performance through telephone calls, e-mails and periodic on-site meetings

Your Benefits

- Affordable alternative to skilled patient account manager
- Continuity of management services (no backlog or limited access due to sick time or vacation)
- Access to professionals experienced in all aspects of patient account management
- Ongoing monitoring of performance by objective third party
- Extra emphasis on achieving department cash goals
- Identification of ways to improve reimbursements
- Mentoring and education of key personnel
- Benefits of outside consultants without loss of control

Your Challenge

If your facility is like most, it has become an ongoing struggle to establish and maintain adequate Patient Access procedures due to constant government/third-party insurance changes, staff turnover, training and system limitations. This common situation often results in registration errors, little or no pre-verification of insurance coverage, and the absence of an effective collection policy for insurance deductibles and co-pays. But how do you implement the critical changes necessary for lasting improvement?

Our Service

Revenue Cycle Solution's experienced Patient Access Consultants will analyze all aspects of your current Patient Access operations and focus on ways to improve use of scheduling, pre-registration and capture of pertinent account information.

Patient Access problems typically stem from multiple sources. They are most often the result of deficiencies in a number of areas including education, training, staffing levels, workflow, and/or poorly implemented computer software. Each deficiency must be addressed as part of a coordinated solution necessary to obtain long-term improvement.

Our Patient Access Review begins with the establishment of baseline measurements of a provider's Patient Access performance, including the development of applicable indices and benchmarks.

We'll send experienced Patient Access Consultants onsite to gather information necessary to assess department staffing, skills, processes and system usage. Our consultants work closely with your organization's existing multi-disciplinary teams with minimal disruptions to your daily operations.

We review the following areas and provide you with specific findings and recommendations:

-  Patient Scheduling
-  Insurance Verification
-  Pre-registration
-  Emergency Registration
-  Outpatient Registration
-  Admissions

We then complete a detailed operational assessment of the Patient Access process to identify deficiencies and opportunities for operational and financial improvements.

As a final step, we provide a written assessment report and supporting work plan of your overall Patient Access operations and recommendations for the creation, implementation and monitoring of workable solutions.

Our Approach

- In-depth discussions with senior management to understand concerns and establish program objectives
- Customized review of operations, including interviews of key management personnel responsible for the day-to-day oversight of various Patient Access processes
- Hands-on participation by senior RCS staff
- Validation of key information by appropriate hospital personnel
- Creation of applicable indices and benchmarks including:
 - Overall scheduling rate for all non-urgent patients
 - Overall insurance verification rate of scheduled patients
 - Overall pre-registration rate of verified patients
 - Insurance verification rate of unscheduled high-dollar outpatients within one business day
 - Payment request rate for insurance co-pays/deductibles
 - Real-time collection rate of insurance co-pays/deductibles
- Detailed analysis and documentation of all significant Patient Access processes, including identification of issues relating to compliance with HIPAA privacy regulations
- Timely completion of work. Our entire assessment is typically completed within four to six weeks after obtaining all pertinent information.
- Detailed management report containing all significant findings and opportunities

Your Benefits

- Written work plan provides an easy and effective process to create, implement and track suggested changes for improvement.
- Typical improvements include:
 - Increased scheduling of all non-urgent patients
 - Increased pre-verification of insurance
 - Adoption of pre-registration process for all non-urgent patients
 - Increased cash flow through significant increase in the real-time collection of insurance co-pays and deductibles
 - Greater accuracy and completeness of account information
 - Reduction of associated claim edits and denials
 - Improved patient convenience and satisfaction

Your Challenge

Underpaid managed care claims have grown to become a very serious problem at many hospitals. Seeking a high Return on Investment (ROI) solution to this dilemma can be a daunting task as many facilities do not have the resources, expertise, or time to diligently monitor the accuracy of payments. Some managed care payers have a consistent record of dramatically underpaying claims. These underpayments must typically be recovered within one year or all recourse is forfeited. **How can you collect these underpayments from managed care payers?**

Our Service

RCS has established an impressive track record of performing managed care audit work at many large hospitals and health systems. Our unique results-based process has allowed us to identify several managed care payers that fall into this damaging category of underpaid claims. RCS will gather and evaluate the hospital's managed care contracts and analyze past claims. We can audit your contractual payment compliance and appeal your clinical denials.

Our Approach

RCS conducts a thorough and in-depth analysis of current managed care contracts to gain knowledge of the terms and fees provided. We will also collect key documents including the contracts, amendments, etc. to review payment fulfillment and accuracy. We obtain key data related to the claims associated with the contracts to conduct an audit to identify and recover unpaid claims.

Your Benefits

Our experienced professionals will positively impact your cash flow through additional managed care reimbursement. RCS takes the time to gain a comprehensive understanding of the contracts and address any discrepancies. In addition to receiving advice and consultation about the managed care contracts, you will be able to:

- Increase cash flow
- Capitalize on lost net revenue
- Improve future billing practices
- Educate staff on acquired knowledge of managed care contracts and their fiscal impact
- Discover contractual issues and make necessary adjustments when renegotiating new terms