Greenway Revenue Services

Identifying Common Revenue Leaks
Identifying and Quantifying Common Revenue Leaks

• Taking the financial pulse of your practice:
Using KPIs to Identify Revenue Leaks

“If you can’t measure it, you can’t manage it.”

- Michael Bloomberg, CEO of Bloomberg, Inc.

• Purposes of KPIs:
  □ View a snapshot of performance for an organization, department or individual
  □ Assess performance and determine root causes of problem areas
  □ Set goals, expectations and incentives
  □ Trend performance over time for a selected group

Source: Bearing Point, Key Performance Indicators
## Most Common Opportunities

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Front and back office accountability</td>
<td>Training &amp; Process</td>
</tr>
<tr>
<td>Billing improper procedure or diagnosis codes</td>
<td>Automation &amp; Technology</td>
</tr>
<tr>
<td>Insufficient billing edits</td>
<td>Automation &amp; Technology</td>
</tr>
<tr>
<td>Lack of flexibility in payment options</td>
<td>Private Pay Management</td>
</tr>
<tr>
<td>Poorly designed patient statements</td>
<td>Automation &amp; Technology</td>
</tr>
<tr>
<td>Deficiencies in technology</td>
<td>Automation &amp; Technology</td>
</tr>
<tr>
<td>Slow bad-debt process</td>
<td>Private Pay Management</td>
</tr>
<tr>
<td>Lack of workflow prioritization</td>
<td>Training &amp; Process</td>
</tr>
<tr>
<td>Billing &amp; follow-up lags</td>
<td>Training &amp; Process</td>
</tr>
<tr>
<td>New vs. existing patients</td>
<td>Training &amp; Process</td>
</tr>
</tbody>
</table>
Front-End and Back Office Accountability

- It all boils down to accountability:
  
  *If they can see it, they can manage it!*

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checked-In not Checked-Out</td>
<td># Visits Checked Out ÷ Total Visits</td>
<td>100% updated by end of day</td>
</tr>
<tr>
<td>Time of Service Collections</td>
<td>Total TOS Collections ÷ Goal</td>
<td>100% of goal</td>
</tr>
</tbody>
</table>
| Rejections and Denials:                  | Total Rejections (and/or Denials) ÷ Total Claims | High Performer- <5%  
| Incorrect Insurance or Demographic Info  |                                          | Solid Performer- < 15%     |
| No Authorization                         |                                          |                            |
| Timely Filing                            |                                          |                            |
| % of Visits w/ Authorization             | \# of Visits w/Auth ÷ Total Visits       | High Performer- > 90%  
|                                          |                                          | Solid Performer- >80%      |
| % of Estimates Performed                 | \# of Estimates Performed ÷ Total Visits | High Performer- > 90%  
|                                          |                                          | Solid Performer- > 80%     |
Procedure and Diagnosis Codes

• **Stay on top of changes:** Beneficial coding changes can help increase revenue

• **Example:**

  **Codes 99415 & 99416**
  - Prior to 2016, observation care provided by clinical staff under the supervision of a physician or other healthcare professional were considered part of the office or outpatient services. This year, two new add-on codes are available for reporting prolonged clinical staff observation services in the outpatient and office settings:
    • 99415- Prolonged clinical staff service (the service beyond the typical service time) during and evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (list separately in addition to code for outpatient Evaluation and Management service).
    • 99416- Each additional 30 minutes ( list separately in addition to code for prolonged service.

**KPIs to Watch:**

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Rejections and/or Denials due to Coding Issues</td>
<td># of Total Rejections or Denials ÷ Total Claims</td>
<td>High Performer- &lt; 2% Solid Performer- &lt; 5%</td>
</tr>
<tr>
<td>Clean Claims Rate</td>
<td># of Clean Claims ÷ Total Claims</td>
<td>High Performer- &gt; 90% Solid Performer- &gt; 85%</td>
</tr>
<tr>
<td>Reimbursement per Procedure</td>
<td>Reimbursement per Procedure Code ÷ Expected Reimbursement</td>
<td>High Performer- 100% Solid Performer- &gt; 95%</td>
</tr>
<tr>
<td>% of Claims Held due to Coding Issues</td>
<td>% Held due to Coding ÷ Total Claims</td>
<td>High Performer- &lt; 2% Solid Performer- &lt; 5%</td>
</tr>
</tbody>
</table>

Source: *Healthcare Business Monthly, 2016 Brings Opportunity to Increase Revenue*
Billing & Charge Edits

• The only constant is change:
  – Requirements change with the wind
    • The average clean claims rate for most practices is between 75-80%
    • The cleaner the claims, the quicker the payment
  – The KPIs to Watch:
    (Similar to Procedure & Diagnosis Codes)

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
</table>
| % of Rejections and/or Denials due to Coding or Billing Issues | \# of Total Rejections or Denials \div Total Claims | High Performer- <5%
                                                          |                               | Solid Performer- < 15%       |
| Clean Claims Rate                        | \# of Clean Claims \div Total Claims         | High Performer- > 90%      |
                                                          |                               | Solid Performer- > 85%      |
| % of Claims Held due to Coding or Billing Issues | % Held due to Coding or Billing \div Total Claims | High Performer- < 2%        |
                                                          |                               | Solid Performer- < 5%       |

• Staying current on charge edits:
  – Employ coders & certified medical billers
  – Audit denials for trends
Flexible Payment Options

• Overcoming the “Just bill me” objection:

A 2009 McKinsey Survey of Retail Health Care Consumers found that 37% of insured patients didn’t pay due to lack of financing options.

• Best practices
  – Offer financing options for large patient responsibilities
  – Offer estimates and payment arrangements prior to the date of service
  – Prepare the patient ahead of time
  – Offer prompt-pay discounts

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOS Collections Goal</td>
<td>Total TOS Collections ÷ *Goal</td>
<td>100% of goal</td>
</tr>
<tr>
<td>Balance After Insurance (BAI) Collections</td>
<td>Total BAI Collections ÷ Total Due</td>
<td>High Performer- &gt; 60% Solid Performer- &gt; 50%</td>
</tr>
<tr>
<td>Bad Debt Percentage</td>
<td>Total Bad Debt Dollars ÷ Total Gross Charges</td>
<td>High Performer- &lt; 3% Solid Performer- &lt; 7%</td>
</tr>
</tbody>
</table>

*TOS Collection Goal is usually set as a % of estimated patient responsibility.
Better Patient Statements

- **If the bill is difficult to understand, it probably ends up in the trash**
  
  A 2009 McKinsey Survey of Retail Health Care Consumers found that 8% of insured patients didn’t pay because they were confused about their bill.

- **Making the bill easier to read**
  - **What, who, how, when, why**
    - **What:** What was the service for and what do I owe?
    - **Who:** Who treated me, who has been billed and who has paid what?
    - **Where:** Where was I treated?
    - **How:** Prominently display payment instructions (URL, addresses, etc.)
    - **When:** When was the service and when is my payment due?
    - **Why:** Why do I owe this much (I thought insurance paid more?)

### KPIs to Watch:

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOS Collections Goal</td>
<td>Total TOS Collections ÷ *Goal</td>
<td>100% of goal</td>
</tr>
<tr>
<td>Balance After Insurance (BAI)</td>
<td>Total BAI Collections ÷ Total Due</td>
<td>High Performer- &gt; 60%</td>
</tr>
<tr>
<td>Collections</td>
<td></td>
<td>Solid Performer- &gt; 50%</td>
</tr>
<tr>
<td>Bad Debt Percentage</td>
<td>Total Bad Debt Dollars ÷ Total Gross Charges</td>
<td>High Performer- &lt; 3%</td>
</tr>
<tr>
<td>Payments from Patient Statements</td>
<td># of Payments Received (in lockbox from Patient Statements) ÷ # of Statements Sent</td>
<td>High Performer- &gt; 25%</td>
</tr>
</tbody>
</table>

*TOS Collection Goal is usually set as a % of estimated patient responsibility.
Helpful Technology

• The easier the process the better the outcome
  – The largest opportunity is in private pay
    • Patient responsibilities are increasing by an average of 15% a year

• Helping simplify the process

KPIs to Watch:
(Similar to the Patient Statements)

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOS Collections Goal</td>
<td>Total TOS Collections ÷ *Goal</td>
<td>100% of goal</td>
</tr>
<tr>
<td>Balance After Insurance (BAI) Collections</td>
<td>Total BAI Collections ÷ Total Due</td>
<td>High Performer- &gt; 60% Solid Performer- &gt; 50%</td>
</tr>
<tr>
<td>Bad Debt Percentage</td>
<td>Total Bad Debt Dollars ÷ Total Gross Charges</td>
<td>High Performer- &lt; 3% Solid Performer- &lt; 7%</td>
</tr>
<tr>
<td>% of Estimates Performed</td>
<td># of Estimates Performed ÷ Total Visits</td>
<td>High Performer- &gt; 90% Solid Performer- &gt; 80%</td>
</tr>
<tr>
<td>% of Patient Portal Payments</td>
<td># of Payments through Portal ÷ Total # of Private Pay Payments</td>
<td>High Performer- &gt; 50% Solid Performer- &gt; 30%</td>
</tr>
</tbody>
</table>

Patient Portals
Estimating Software
Registration Kiosks
Reporting Analytics
Slow Bad-Debt Process

• The longer you hold onto private pay A/R, the more it costs
  
  – It needs a closer look if:

  Your 121-150 Bucket Private Pay A/R is > 15% of your total A/R

  OR

  70% of Your 121-150 A/R Bucket is private pay

• Managing bad debt
  
  – Have a consistent statement cycle
  – Have a consistent bad-debt policy
  – Establish upfront expectations when you hire a collection agency and manage them well

KPIs to Watch:

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Pay Days in A/R</td>
<td>Private Pay A/R ÷ Average Daily Revenue</td>
<td>High Performer- &lt; 6.75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Solid Performer- &lt; 10</td>
</tr>
<tr>
<td>121-150 Bucket Private Pay A/R as % of</td>
<td>121-150 Bucket Private Pay A/R ÷ Total A/R</td>
<td>High performer- &lt; 10%</td>
</tr>
<tr>
<td>Total A/R</td>
<td></td>
<td>Solid Performer- &lt; 15%</td>
</tr>
<tr>
<td>121-150 Bucket Private Pay A/R as % of</td>
<td>121-150 Bucket Private Pay A/R ÷ Total 121-150</td>
<td>High Performer- &lt; 40%</td>
</tr>
<tr>
<td>Total 121-150 Bucket A/R</td>
<td>Bucket A/R</td>
<td>Solid Performer- &lt; 60-70%</td>
</tr>
</tbody>
</table>
Workflow Prioritization

• Getting your biggest bang for your buck...

  – Prioritization leads to:
    • Lower denials
    • Higher reimbursement
    • Healthier A/R
    • Operational efficiency

• Prioritizing workflows
  – High dollar
  – High age
  – Timely filing limits
  – Complexity
  – Experience (of biller)

KPIs to Watch:

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely Filing Denials as % of Total Claims</td>
<td>Denials for Past Timely Filing (PTF) ÷ Total Claims</td>
<td>High Performer- &lt; 1% Solid Performer- &lt; 2.5%</td>
</tr>
<tr>
<td>Daily: Total Charges Billed as % of Total Charges in Queues</td>
<td>Total Charges Billed ÷ Total Charges in Billing Queue</td>
<td>High Performer- 100% Solid Performer- &gt;95%</td>
</tr>
<tr>
<td>Total Claims Worked per Day</td>
<td># of Claims Worked per Day per Biller</td>
<td>Can depend on specialty and fee schedule but: High Performer- &gt;50 Solid Performer- &gt; 40</td>
</tr>
<tr>
<td>Collection Trend: Six Months</td>
<td>Collections + Total Charges (with 1 month lag)</td>
<td>Can depend on specialty and fee schedule but: High Performer- &gt;45% Solid Performer- &gt; 40%</td>
</tr>
<tr>
<td>A/R &gt; 60 Trend: Six Months</td>
<td>A/R &gt; 60 ÷ Total A/R</td>
<td>High Performer- &gt; 80% Solid Performer- &gt; 75%</td>
</tr>
</tbody>
</table>
# Billing & Follow-Up Lags

### KPIs to Watch:

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Past Follow Up</td>
<td># of Claims &gt; 30 Days Past Documented Follow-Up Date + Total # of Outstanding Claims</td>
<td>High Performer- &lt; 5% Solid Performer- &lt; 10%</td>
</tr>
<tr>
<td>Delinquent Claims</td>
<td># of Claims &gt; 60 Days Past Documented Follow-Up Date + Total # of Outstanding Claims</td>
<td>High Performer- &lt; 2% Solid Performer- &lt; 5%</td>
</tr>
<tr>
<td>Claims Past Timely Filing</td>
<td># of Claims Past Payer-Specific Timely Filing Limits + Total # of Outstanding Claims</td>
<td>High Performer- &lt; 1% Solid Performer- &lt; 2.5%</td>
</tr>
<tr>
<td>Claims Approaching Timely Filing</td>
<td># of Claims w/in 7 days from Timely Filing Limit + Total # of Outstanding Claims</td>
<td>Ideally there would be 0 claims without follow-up by this time in the cycle</td>
</tr>
<tr>
<td>31-60 A/R Bucket Trend</td>
<td>Dollar Change in 31-60 A/R Bucket + Total Prior 31-60 A/R Dollars</td>
<td>Can be cyclical but swings anywhere from 0% or less (reduction) to as high as 5% are normal. An increase of more than 5-7% indicates a closer look is needed.</td>
</tr>
</tbody>
</table>

### To Do List

Follow Up
Follow Up
Follow Up

### Stay on top of your basic blocking and tackling

- Success is in the follow-up
  - Only 62% of practices review delinquent claims

### Keeping follow-up current

- Follow-up every 14-21 days until resolved
- Conduct random audits of high-dollar claims
- Frequently review Delinquent Claims and Claims Past Follow-Up
New vs. Existing Patients

- Long-term relationships:
  - Keep referrals coming
  - Keep paying customers
  - Are less costly to manage

KPIs to Watch:

<table>
<thead>
<tr>
<th>KPI</th>
<th>Formula</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returning Patients</td>
<td>Returning Patients ÷ Total Patients</td>
<td>75-80% but can depend on specialty</td>
</tr>
<tr>
<td>New Patients</td>
<td>New Patients ÷ Total Patients</td>
<td>10-20% but can depend on specialty</td>
</tr>
<tr>
<td>Returning vs. New</td>
<td>Returning Patients ÷ New Patients</td>
<td>A 4-to-1 ratio is normal depending on specialty</td>
</tr>
</tbody>
</table>
How Can We Help?

• Greenway provides a comprehensive suite of services that can assist in optimizing cash flow:
  
  – **Greenway Link**  Are patients receiving text messages to remind them of appointments? An opportunity to minimize lost revenue
  
  – **Greenway Community**  Patient Portals provide an easy way for patients to pay online
  
  – **Greenway Revenue Services**
    
    • Insurance billing
    • Payment posting
    • Patient billing
Greenway Revenue Services

Clinic

SCHEDULE → CHECK-IN → TREAT → DOCUMENT, CODE & POST

Greenway

Insurance Billing
- Submit/Reconcile
- Rejection Work
- Denials
- Delinquent Follow-up

Payment Posting
- Manual
- ERAs
- Adjustments

Patient Billing
- Statements
- Patient Calls
- Payment Plans
- Collections
Insurance A/R Team

- **Client Revenue Manager**
  - Manages specialty and regionally focused team
  - Weekly and monthly consulting
  - Central point of contact

- **Claims Analyst**
  - Unique screening and hiring process
  - Decision tree analytics with each claim
  - Focus on clean-claim ratios

- **Client Success Team**
  - 90-day optimization period oversight
  - Monthly review of metrics
  - Periodic table scrub
Reimbursement Team

- **Payment Posters**
  - Automatic push of denials to worklist
  - Consistent posting turnaround
  - Careful review for undercharging

- **Reimbursement Analysts**
  - Yearly reimbursement change analysis
  - Review for underpayments
  - Monthly ERA optimization review
Patient A/R Center

➢ **Patient Advocate**
  - Sends statement and collection letters
  - Fields all patient calls using practice-assigned 1-800 number
  - Monitors and reports wait times, abandonment rates, and first-call resolution percentages

➢ **Patient A/R Consultant**
  - Monitors trends in patient collections
  - Facilitates employee training and oversight of same-day collection ratios
  - Consults with practices to improve outcomes through best practices and technology
Monthly Revenue Review

• Decision Tree Feedback
  – Coding denials
  – Demographic errors
  – Problems in front office workflow

• Office Staff Reporting Trends
  – Clean claim ratio
  – Same-day collection ratios

• Financial Health Reporting
  – Days in A/R
  – Aging reports
  – Net collection rate
Questions?

My contact information:

Bradley C. Skilton  
Director, Greenway Revenue Services  
Brad.Skilton@greenwayhealth.com  
(407) 585-0776