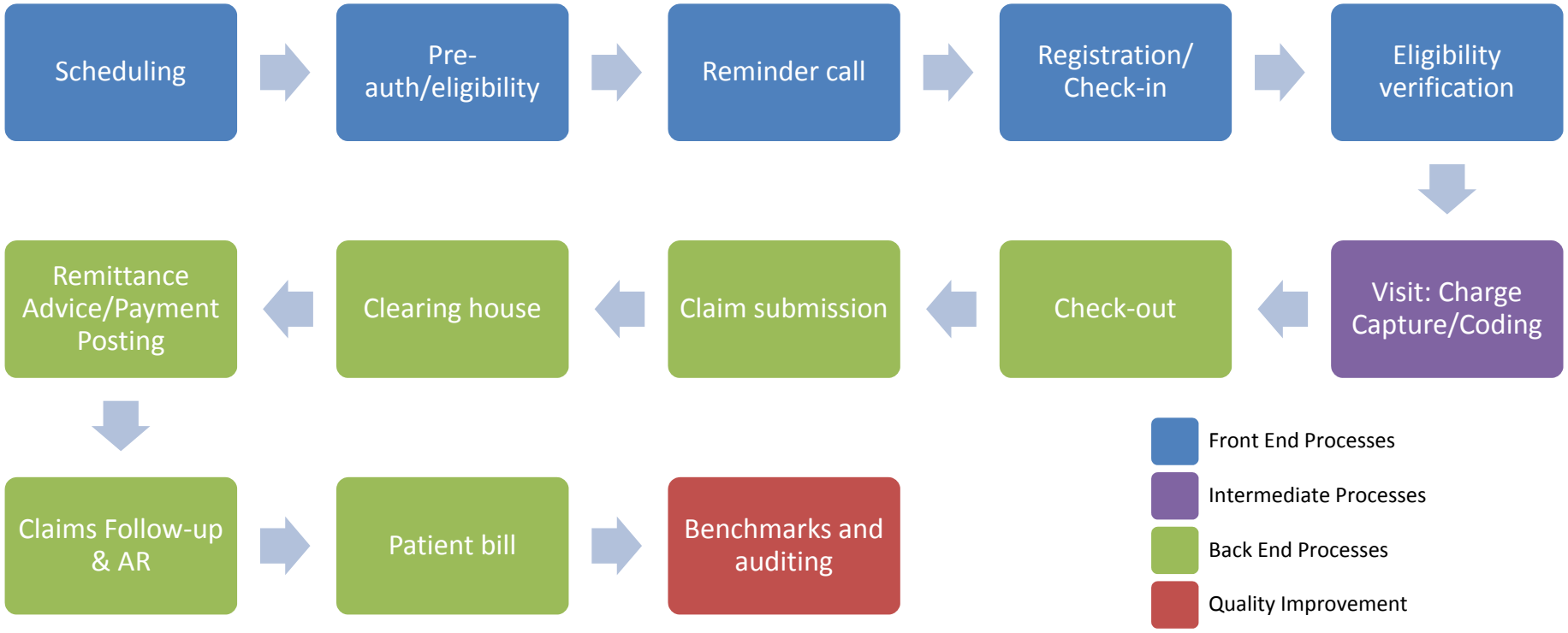
OVERVIEW

It is important for **everyone involved in the billing cycle process to be familiar with how each step of the encounter provides opportunities to assure successful and compliant billing.** The purpose of this document is to demonstrate how **each step in the process impacts** the next as well as the overall revenue cycle of the agency/clinic. For most steps, the desired outcome and the results that may incur should that step not be addressed is discussed. **This document is intended to be used in conjunction with training on policies and procedures, coding and documentation guidelines, and specific payer rules.** It is not a comprehensive tool and should not be used without the aforementioned training.

The content provided in this document is intended for educational purposes only. It is not intended to serve as medical, health, legal or financial advice or as a substitute for professional advice of a medical coding professional, health care consultant, physician or medical professional, legal counsel, accountant or financial advisor. Cardea encourages providers should contact third-party payers for specific information on their coding, coverage and payment policies.

ENCOUNTER

An encounter is created for each client visit. The flow of this encounter begins at the time of booking and flows through the billing and accounts receivable (AR) cycle. The encounter is not complete until the charges have been reconciled completely by payments and/or adjustments.



Revenue Cycle Step	What you can do	How it helps	What happens if you don't
SCHEDULING First step of the encounter- involves making the appointment and setting up the account to prepare for billing and contact. If appointment is booked incorrectly, the patient may need to come back resulting in patient dissatisfaction and lost revenue. **ASSESSMENT QUESTIONS:** *1. Does your agency have an electronic or other system for appointments that collects contact, insurance/payment source, and other patient information?* *2. Do staff who handle appointment scheduling have adequate time to collect detailed pre-visit information (keeping in mind that this saves time at check-in)?* *3. How are staff trained on scheduling and registration processes? Are there protocols or scripts in place?*	The first chance to get current and accurate information and communicate service/financial policies. *Collect:* • Contact info • Demographic information • Insurance info (payer, plan, subscriber, relationship of subscriber to patient, policy and group number if applicable) • Reason for visit *Communicate:* • Review agency financial policy • Discuss payment options • Advise to bring required documents (insurance card, e.g.) • Program coverage (i.e. FP waiver program will not cover infection check)	Contact info- allows you to contact the patient to remind of appts, verify info, and reschedule appts Demographic info- allows to set up or update the patient account Insurance info- allows the clinic to verify eligibility and benefit info prior to the appointment. Reduces work/time at check-in. Reason for visit- supports effective scheduling, may impact program eligibility and service fees Discuss payment options- inform patient about potential programs for which she/he may be eligible Advise to bring req docs- increases likelihood that patient will arrive with needed documents to apply for programs, verify insurance, etc. Program coverage- informs patient if a specific program will or will not cover the visit	Won't be able to reach patient prior to the appointment to discuss prior auths, change appts etc. Patient info may be incorrect, leading to denied claims Clinic will not be able to verify coverage, identify data entry errors, etc. prior to the appt. Increases work/time at check-in, and could result in denied claims Patient may not be scheduled with the appropriate clinical staff or in a correct timeslot Patient may not be prepared to pay fees or not understand what programs are available. Patient may not bring required docs thereby delaying eligibility verification, may not bring insurance info so staff cannot verify data prior to billing. Patient may think a program will cover the visit and will dispute the charge. Patient satisfaction decreases.
PRE-AUTH/ELIGIBILITY Using the info provided at booking to verify eligibility and pre-authorization for the appointment. This step helps to identify data entry errors or missing info. **ASSESSMENT QUESTIONS:** *1. How might your staff verify payment source eligibility (phone, online)?* *2. Does your agency have a Practice Management System that can verify insurance carriers?*	Using the billing info captured at booking, contact the insurance carrier to determine eligibility and seek pre-authorization for specific visits/providers. Also consider seeking benefit info (i.e. actual charges the patient may be responsible for)	Prepares the account for accurate billing, allows clinic to communicate responsibility prior to the appointment, provides authorization numbers when required	Claims may be denied for missing authorization or required referrals; Billing info is not verified which could result in denied claims due to data entry errors etc. Increases staff time at check in

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REMINDER CALL Calling the patient to remind them of the upcoming appointment. Provides opportunity to discuss payment issues. **ASSESSMENT QUESTIONS:** *1. Does your agency/clinic make reminder calls in advance? One day before? Two days before?* *2. Is an email or text reminder sent?*	Call patients two days prior to appointments. Inform them of any eligibility and benefit information captured Review agency financial policy	Reduces no-shows If patient cancels, allows time to fill the slot. If patient confirms, allows adjustments to their schedule to keep the appt, informs the patient about insurance eligibility (if not eligible allows clinic to consider other programs and update account) Reduces staff time at check in and reduces claim denials due to errors	Increased no-show rates Patient unprepared to pay co-pays or balances. Clinic is not able to discuss patient responsibility based on benefit determination and is unable to inform patient of other programs she/he may be eligible for if no insurance coverage is found. Clinic is not able to get corrected information for data entry errors etc.
REGISTRATION/CHECK-IN Verify patient identity, reason for visit; update and prepare the account for the visit. **ASSESSMENT QUESTIONS:** *1. Does your agency have written protocols & procedures for staff to follow during the patient "check-in" process?* *2. How are staff oriented / trained on this "check-in" process?*	Have patient verify all info on file. Copy insurance card, assure subscriber info on file if appl. Discuss program coverage with patient as appl; verify income Review agency financial policy Have patient sign needed forms, including authorizing release of info to payer. Address issues of confidentiality or HIPAA rules (see 2013 Omnibus) as needed. Issue Medicare ABN, if appl. Pre-populate encounter form/ superbill with patient info Collect co-pays, as appropriate	Third verification of data entry and account info. Assures any changes since previous step have been captured, helps staff identify eligible programs for the patient. Reinforces patient understanding of financial policies and their obligation	Data entry errors may not be captured until after claims are submitted, increases denials and AR. Subscriber info may not be on file, account may be missing required documents Clinic staff will not have info needed for public program eligibility Outdated or incorrectly entered contact info will not be corrected Patient may not understand their financial obligation for the services they receive. Patient satisfaction decreases.
ELIGIBLITY VERIFICATION Using the information provided at check-in to verify eligibility. This step helps to identify data entry errors or missing info. **ASSESSMENT QUESTIONS:** *1. How might your staff verify eligibility?* *2. Does your agency have a Practice Mgmt System that can verify insurance?*	Using the billing info captured at booking, contact the insurance carrier to determine eligibility. Also consider seeking benefit info (i.e. actual charges the patient may be responsible for)	Prepares the account for accurate billing; ensures coverage is active at the time of service. Identifies the amount the patient is obligated to pay in the form of deductibles, co-payments or co-insurance	Claims may be denied for lack of coverage at time of service. Billing info is not verified which could result in denied claims due to data entry errors etc.

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VISIT: CHARGE CAPTURE/CODING Documenting and coding all services and capturing as charges. Clinical care documentation should match coding and charge capture. **ASSESSMENT QUESTIONS:** *1. Does your agency use an encounter form/superbill? How is it kept up to date?* *2. Does your agency have written protocols & procedures for staff on documentation, coding and charges?* *3. What is your agency's system for entering service charge data? Do charges match clinical documentation?* *4. How are staff (including providers) trained on documentation/coding?* *5. If you have an EHR, have you checked accuracy of pre-assigned codes?*	Providers utilize an encounter form/superbill (paper or electronic) to document visit. Form should include common services, mapped to CPT codes. Include ICD-9 codes as well. Verify any pre-assigned codes in EHR templates. If using a paper form, submit immediately to staff who will be entering the charges into your billing system. All charges and coding should be supported by appropriate medical documentation. Correct documentation/coding is a partnership between providers and billing staff.	Assures correct medical documentation for billed services (important for audits) Assures that all billable services are captured; no missed revenue opportunities Standardized encounter form/ superbill reduces coding errors	Required eligibility and/or documents for programs may not be captured resulting in patient dissatisfaction, increased provider work at a later date, missed services for the client All billable services may not be captured, resulting in missed revenue opportunities Claims may be denied due to coding errors Claims may be denied following chart review as a result of missing documentation - ALSO required for compliance and if not sufficient will result in less than optimal audit findings
CHECK-OUT Ending the patient portion of the encounter **ASSESSMENT QUESTIONS:** *1. Does your agency have written protocols & procedures for staff for the patient "check-out" process?* *2. How are staff trained on this process?* *3. Is your agency able to provide patients with a detailed bill that shows details of encounter, pay source(s), payments, pending balance, etc.?* *4. Does your agency have policies/ procedures to collect patient fees, if applicable? Would fee collection fit better at check-in?*	Review and post charges Print bill/receipt and discuss charges with patient, including if insurance will be billed, if the services are covered by a program, and/or what portion the patient is responsible for (be sure to apply sliding fee scale as applicable) Discuss a payment plan with patient as appropriate If any patient payment received, enter immediately into patient account Reconcile accounts at end of day	Facilitates timely filing of claims Allows clinic to inform patient of balances less adjustments (i.e. sliding fee) Discussion of payment plan increases likelihood that payment will be made Allows the clinic to print a statement of today's encounters, charges, payments (if applicable) and balances and reconcile all records	Claims may not be billed in a timely manner resulting in increased AR Clinic cannot inform patient of balances, adjustments Missed opportunities to discuss fees with patients and collect as appropriate Clinic cannot print out a statement of today's charges, may lack necessary internal financial controls

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CLAIMS SUBMISSION Preparing and submitting the claim to clearinghouse or direct to payers. **ASSESSMENT QUESTION:** *1. Does your agency have a Practice Mgmt system with a "review" feature?*	Establish a claims submission schedule (i.e. daily, weekly). Review charges and codes, verify all charges are captured and posted correctly. Many Practice Mgmt systems have built in claims scrubbers/edits.	Reduces claims denials and/or erroneous billing (i.e., posted to patient when should go to insurance), assures accurate insurance info is on the claim including provider, taxonomy, id numbers, etc.	Denied claims increase, AR increases, may result in write-offs, charges may be "missed" resulting in lost revenue.
CLEARINGHOUSE Third party that submits HIPAA compliant claims on the provider's behalf. Provides additional edits prior to sending claims. **ASSESSMENT QUESTION:** *1. Does your agency use a clearinghouse (third party) to review claims (using edit codes) before being sent to the payer?*	By assuring accurate info in the above steps, clearinghouse edits will identify fewer errors	Claims are processed faster and don't require additional staff time to correct errors. Results in faster insurance processing	If you don't use a clearinghouse, you may submit claims from your practice management system or direct to the carrier. You don't get the benefit of additional edits and may need to devote more staff time to correcting denied claims.
REMITTANCE ADVICE (RA)/ PAYMENT POSTING Clean claims will be paid, applied to co-insurance or deductible, or denied. RA is the info sent to the provider explaining how payments or denials were applied. **ASSESSMENT QUESTION:** *1. How is payment/other RA information posted into your revenue mgmt system?*	Billing staff will post payments and denials based on the remittance advice.	Remittance advice provides specific payment and denial reasons Timely posting of payments ensures updated balances and correct AR management Updated balances open opportunities to pursue reimbursement through secondary insurance or patient billing, as appropriate	Failing to post payments and denials in a timely manner results in the clinics inability to manage AR and reconcile billing. The clinic also cannot communicate denials, outstanding balances, etc. with the patient
CLAIMS FOLLOW-UP/AR Tracking submitted claims to ensure receipt by payer. Taking appropriate action (modify, appeal or write-off) in response to denials or partial payments. **ASSESSMENT QUESTIONS:** *1. How often does the agency review AR?* *2. Does your agency have systems to track if a payer has not acted on a claim?* *3. Does your agency regularly modify or appeal denied claims, as appropriate?*	Follow up on unpaid claims. Post payments and denials as soon as possible following receipt of the RA. Know required payer timelines for modifying/appealing claims. Quickly correct and re-bill claims denied for billing errors. Review outstanding claims regularly, correct, reprocess or contact carriers as appropriate.	Claims corrected quickly will reduce "days in AR" and identify problems Many denied claims contain easily corrected errors; modifying and resubmitting will lead to increased revenue Documented denials from primary payers will enable billing of secondary payers, as appropriate	Claims may be denied due to untimely filing; AR increases, staff time increases, staff continue to make same/like errors Not attempting to correct denied claims is a missed opportunity for revenue

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PATIENT BILLING Based on the remittance advice, the claim may be billed to the patient. Patient billing may also be appropriate for patients who are uninsured or do not wish to bill their insurance, assuming ineligibility for programs and sufficient income. Always ensure compliance with payer requirements (including Medicare/ Medicaid) before billing patients. **ASSESSMENT QUESTIONS:** *1. How is this info passed along to the patient? Is this process automated?* *2. In what ways does your agency make payment easy/convenient for patients?* *3. Does your agency have written protocols & procedures outlining when balances should be billed to patients and how fee info should be communicated?*	Bill patient balances on a regular basis 2-3 times/month Send patient statements at least monthly; include denial codes and demonstrate how payments were applied. Include previous balances/payments. Send internal "collection" letters or phone calls for balances with no activity or missed payment plans. Provide multiple payment options, including online and telephone, and credit cards if possible	Billing patients asap following claims submission allows them to easily compare charges with EOB while the visit is still fresh in their mind. Patients billed soon following service are more likely to pay on the account. Reduces patient AR. After sending a couple of statements with no response, sometimes sending a letter or making a call will indicate the importance of their responsibility. Be sure to provide contact info for questions. Providing a means of making payments other than written checks increases patient payments	Patient refuses to pay for the visit from "last year" for example; patient has tossed or misplaced the EOB. Patient doesn't pay until billed by the clinic so patient AR is increased until billing If the statement didn't match the EOB or the denial codes were not indicated, the patient may dispute the bill.

BENCHMARKS & AUDITING/QI This is not part of the encounter directly. Benchmarking compares your processes/ results to best practices. QI efforts can improve your processes. **ASSESSMENT QUESTION:** *1. Does your agency identify benchmarks within your billing cycle? (see below)*	Identify standards for practices, establish current baseline and develop plans to improve processes to meet the benchmark	Establishes goals and helps the clinic to develop plans to meet benchmarks and make improvements. Increases efficiency, reduces AR, reduces errors, facilitates training, increases staff morale	You don't know where you stand or if your processes are effective or can be better. AR may increase, staff morale may go down, errors may increase

Common benchmarks include:

- Days in AR
- Claim denials
- Data entry errors
- AR by bucket and overall
- New/Est. patient
- Collections Rate
- Unbilled charges
- Missing charges
- No Show rates
- Reminder call rates
- Provider Productivity
- Gross Charges
- Payer Mix
- Patient Satisfaction
- Patient Retention