

# The Revenue Cycle-It Really Is About the Patient!

29 August 2017 0800-0900 EDT

31 August 2017 1400-1500 EDT

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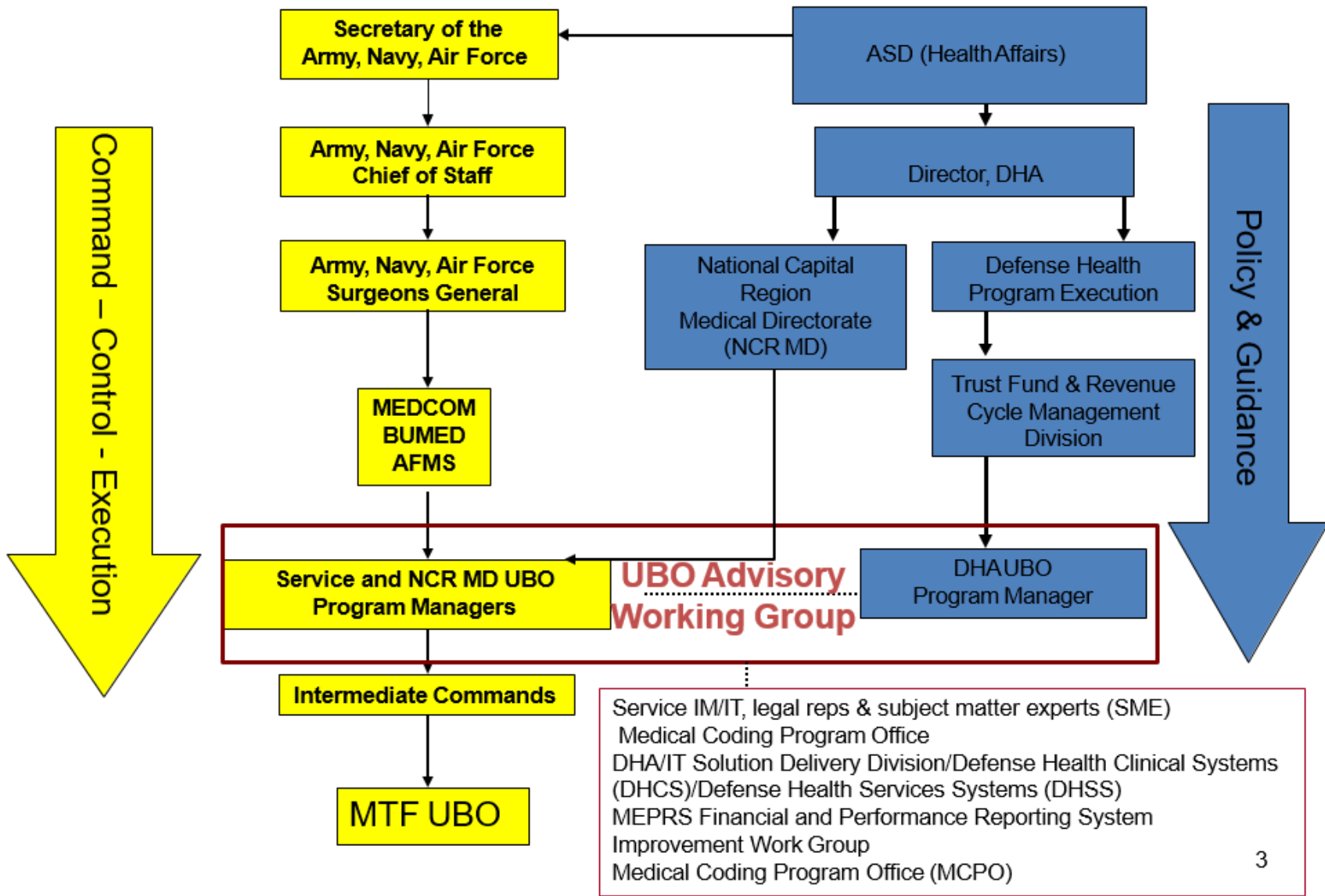
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- Explore the Uniform Business Office (UBO) Organization and UBO Cost Recovery Programs
- Define the revenue cycle
- Describe the “Theory of Limiting Constraints” and the significant impact upon the healthcare delivery process to include the revenue cycle
- Understand and appreciate the synergistic approach to a strong Revenue Cycle
- Identify and operationalize the concept of “Denials Avoidance” into the revenue cycle through collaboration and training



# Uniform Business Office (UBO) Organization



## Third Party Collections (TPC)



Medical Services  
Account (MSA)

Medical Affirmative  
Claims (MAC)



# Who Gets Billed Under Which Program?

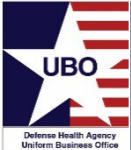
- Third Party Collections
  - Bill insurers for care provided to eligible DoD beneficiaries (excludes Active Duty) with other health insurance (excluding Medicare & TRICARE)
- Medical Services Account
  - Includes billing for care provided to eligible patients from Veterans Affairs/Coast Guard /NOAA/ PHS/Civilian Emergencies/Foreign Military & their Family Members
- Medical Affirmative Claims
  - Bill for care provided to eligible DoD beneficiaries (including active duty) injured by third parties

## 32 CFR §220.2 Statutory obligation of third party payer to pay.

*(a)Basic rule.* Pursuant to 10 U.S.C. 1095(a)(1), a third party payer has an obligation to pay the United States the reasonable charges for healthcare services provided in or through any facility of the Uniformed Services to a covered beneficiary who is also a beneficiary under the third party payer's plan. ***The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.***

*(b)Application of cost shares.* If the third party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then ***the amount the United States may collect*** from the third party payer ***is the reasonable charge for the care provided less the appropriate deductible or copayment amount.***

*(c)Claim from United States exclusive.* ***The only way for a third party payer to satisfy its obligation*** under 10 U.S.C. 1095 ***is to pay the facility*** of the uniformed service or other authorized representative of the United States. ***Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095.***

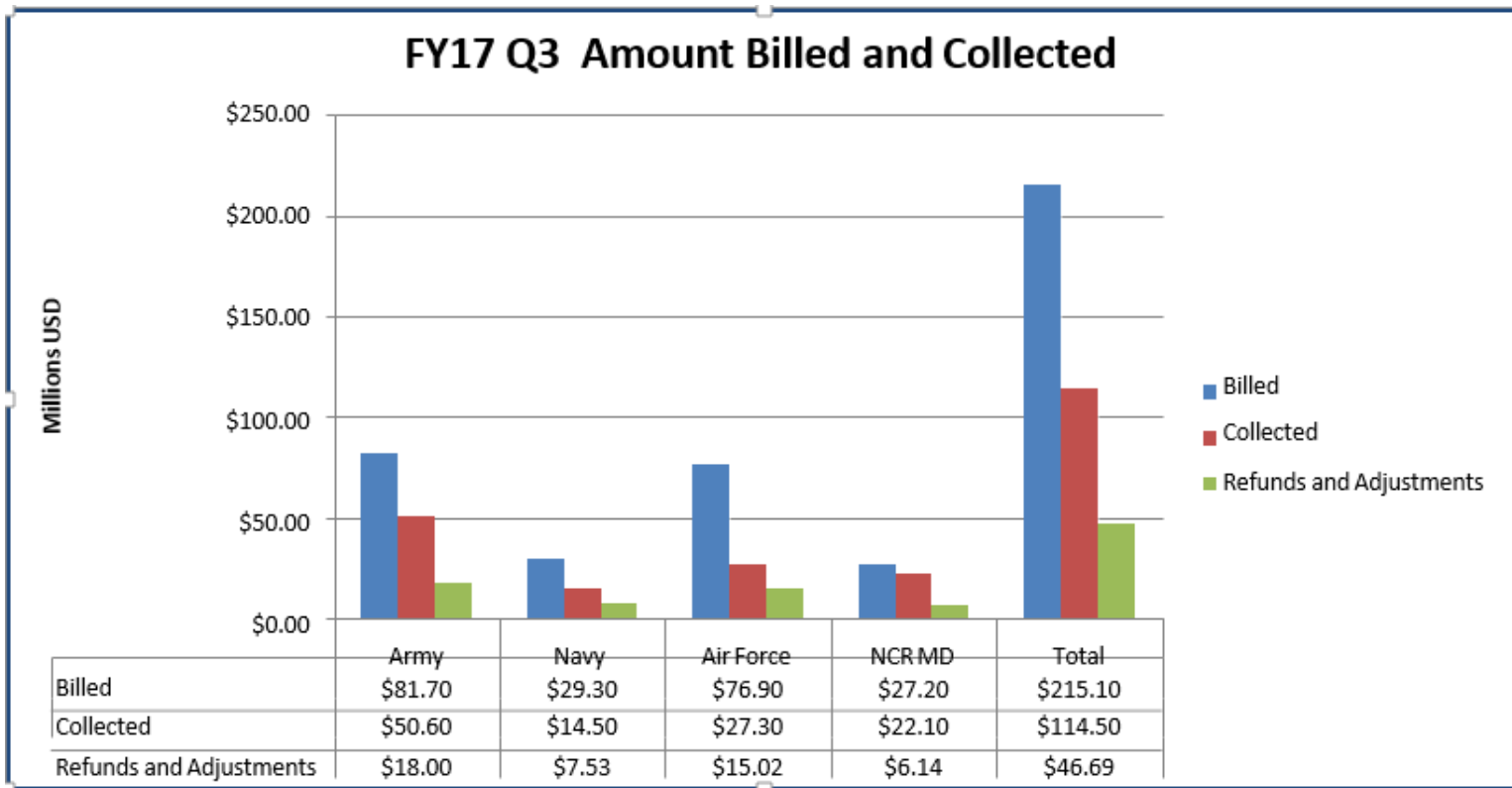


# Approximate Annual Collections by Cost Recovery Program

- Third Party Collections Program (TPCP)
  - \$150M
- Medical Services Account (MSA)
  - \$350M
- Medical Affirmative Claims (MAC)
  - \$13M
- ALL funds collected are retained by your MTF
  - TPC funds are in addition to the MTFs O&M budget

# Total Amount Billed and Amount Collected

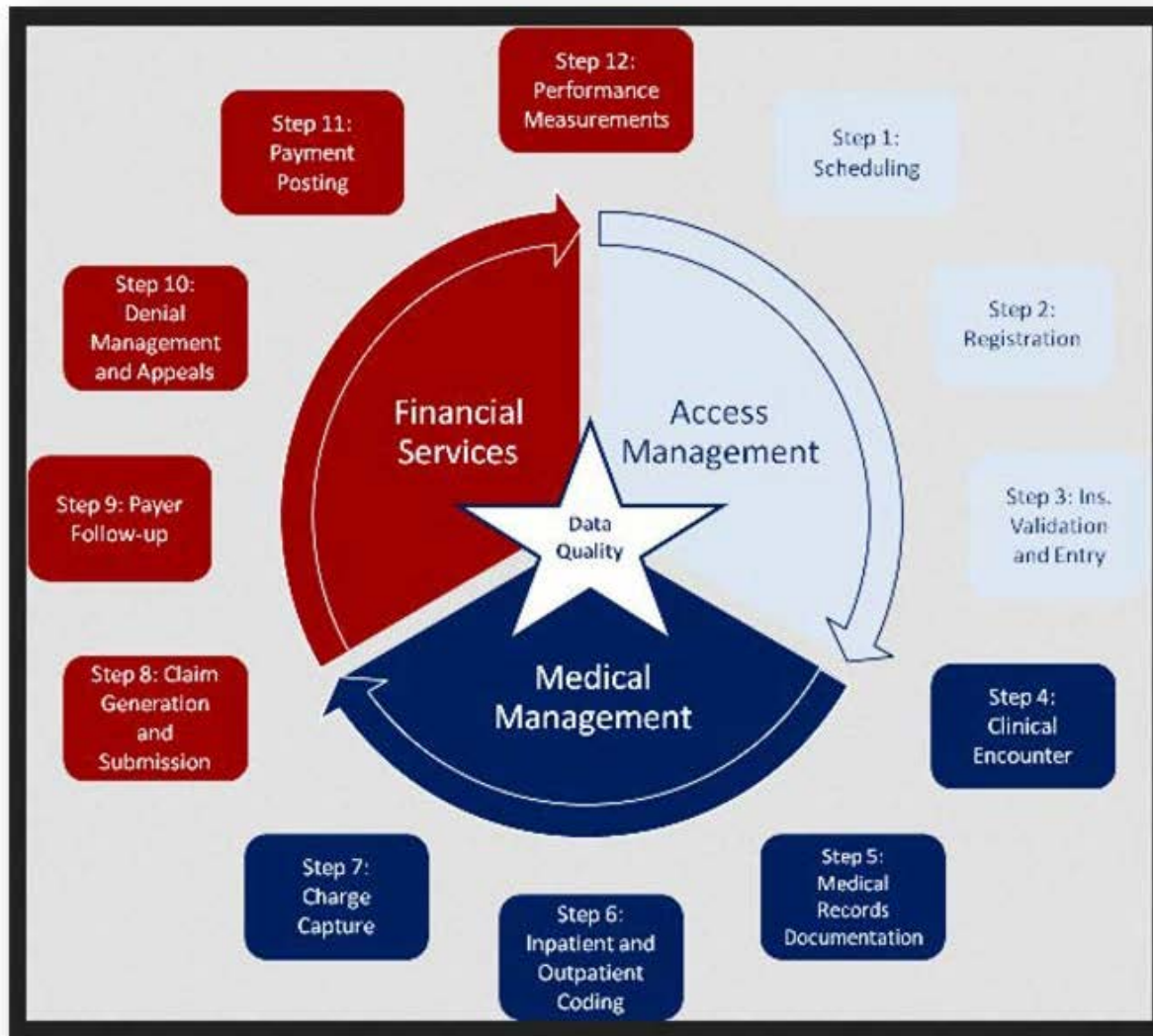
There is a large gap between amount billed and amount collected  
 Optimization of the full revenue cycle is essential for closing this gap



*From FY12-FY16, **54%** of total MHS uncollected dollars can be attributed to acceptable third party payer denials (co-pay, deductibles, out of network, non-covered benefits)*



## MHS Revenue Cycle Management (RCM)



*The success of UBO Programs is dependent of the entire revenue cycle!*

- **Revenue Cycle**

- "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

- **Fundamental Conditions for a Successful Revenue Cycle**
  - **Right Care**
  - **Right Time**
  - **Right Reason**
  - **Right Setting & Venue**
  - **Right Documentation**
  - **Right Clinical Judgment & Medical Decision-Making**

- **Revenue Cycle is analogous to water flowing from the smallest stream to the ocean**
  - Stream flows into large river to ocean
  - Billing synonymous with ocean
  - Clinical information that may seem insignificant may have major impact on reimbursement
  - Downstream repercussions from issues in early phases of the revenue cycle lead to incorrect or incomplete billing information, rework and lower recovery
  - Dikes, sandbags & flood zones (think of UBO work arounds are used to patch systemic problems)



# Interdependence and other Revenue Cycle Concepts



- **There is More than Meets the Eye**
- **Revenue Cycle Approaches**
  - Interdependent vs. Stand Alone
  - Vacuum Cleaner vs. Cyclone
  - Silo Approach vs. Holistic
  - Role vs. Task
  - Patient Focus vs. Process Focus
- **Within the approaches we need to adopt we should also recognize the constraints**



- **Theory of Constraints**
  - Methodology for identifying the most important **limiting** factor (i.e. **constraint**) that stands in the way of achieving a goal and then systematically improving that **constraint** until it is no longer the **limiting** factor. In manufacturing, the **constraint** is often referred to as a bottleneck
  - Based upon the assertion that: “Every real system, such as a business, must have within it at least one constraint (limiting factor)”
  - Often times there is more than one constraint
  - In optimizing the revenue cycle it is essential we recognize constraints

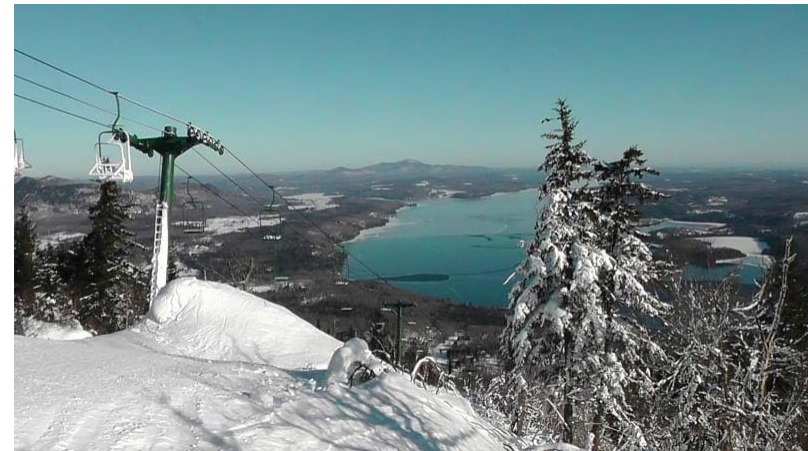
- **Six types of constraints potential to hold back revenue cycle**
  1. **A Logical Constraint** - Faulty thinking or assumptions can block success (e.g., believing people are the problem when ineffective systems—hiring, training, and so forth—are the real problem)
  2. **A Process Constraint** – The output of work processes is reduced by a weak-link or bottleneck in the process (e.g., work piled up in an in-basket; inventory waiting to be processed)
  3. **A Self-inflicted Constraint** – A company's culture, rules, or policies can have a detrimental effect on results (e.g., lack of accountability, not hiring older people; sticking with the "sacred cows" of work practices)



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5. **Personal Constraint** – Personal traits of an owner or manager can hinder performance (e.g., disorganization, procrastination, perfectionism, indecision, fear, incompetence, lack of time, or failure to face problems). Do you have any beliefs or behaviors that are holding back your business?
  
6. **An External/Market Constraint** – Obstacles can exist that you have no control over (e.g., market size; customer attitudes; competition; the economy). You can often adapt to these external constraints over time by adjusting your business strategy



Now that we have a better understanding of the revenue cycle and theory of constraints, we are in a better position to take a proactive approach to revenue cycle operations



## Reactive

- Acting in response to a situation rather than creating or controlling it
  - *'a proactive rather than a reactive approach'*
- (of a disease or illness) caused by a reaction to something
  - *'reactive arthritis'*
  - *'reactive depression'*
- Relating to reactance
  - *'a reactive load'*

## Proactive

- Relating to, caused by, or being interference between previous learning and the recall or performance of later learning  
proactive inhibition of memory
- Acting in anticipation of future problems, needs, or changes

**Now let's look at a case study**



## Patient experience:

- The beneficiary's primary care physician, saw the patient in the office for follow-up for acute bronchitis where patient was prescribed a seven day course of Z-pak (antibiotics). The physician noticed patient was due for her ten year "screening" colonoscopy. Of note patient updated current insurance information to reflect her new employer that offered comprehensive health insurance
- During the encounter the patient mentioned she was having trouble moving her bowels

- **Physician Documentation**

- Acute bronchitis-finished seven day course of antibiotics, Currently cough free, no temperature, no further respiratory complaints
- Minor abdominal pain now and then related to constipation likely related to dehydration, patient stays out in the sun for extended periods of time obviously not consuming enough fluid

- **Plan**

- Schedule a screening colonoscopy as soon as possible, patient is overdue for 10 year screening colonoscopy, no GI complaints except for occasional constipation related to low fluid intake



# Physician Order

Community Hospital  
123 Main Street  
Anytown, USA 56789  
555-555-3224

Patient Name  
DOB XX/XX/XXXX  
30/XXXX



**DX:** Screening colonoscopy, occasional constipation, infrequent

**Procedure:** Screening colonoscopy



## **ACCEPTABLE OPERATIVE REPORT # 1**

**This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to:**

- **identify the patient**
- **support the diagnosis**
- **justify the treatment**
- **document the postoperative course and results**
- **promote continuity of care**

**This operative report also provides:**

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

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Blair General Hospital  
123 Main Street  
Anytown, USA 56789

Patient Name: Betty Doe

Date: January 1, 2005

Preoperative Diagnosis: Bilateral upper eyelid dermatochalasis

Postoperative Diagnosis: Same

Procedure: Bilateral upper lid blepharoplasty, (CPT 15822)

Surgeon: John D. Good, M.D.

Assistant: N/A

NAME: Doe, William

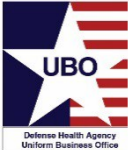
Anesthesia: Lidocaine with 1:100,000 epinephrine

Anesthesiologist: John Smith, M.D.

Dictated by: John D. Good, M.D.

This 65-year-old female demonstrates conditions described above of excess and redundant eyelid skin with puffiness and has requested surgical correction. The





## Key information from Operative Report Used for Coding

**Preoperative Diagnosis:** Screening colonoscopy, occasional constipation

**Postoperative diagnosis:** Screening colonoscopy, occasional constipation, 2 sessile polyps removed, sent to pathology

**Procedure performed:** Colonoscopy, snare polypectomy X 2, sent to pathology for definitive diagnosis

## Diagnoses & Procedure

- **Diagnoses**

- Constipation
- Polyps X 2

- **Procedure**

- Colonoscopy with polypectomy X2

## ICD-10 & CPT Coding

- K59.00- Constipation unspecified
- D12.4- Benign neoplasm of colon, unspecified
- 45385- Colonoscopy flexible with removal of tumor(s), polyps(s), or other lesion(s) by snare technique
- 45385- Colonoscopy flexible with removal of tumor(s), polyps(s), or other lesion(s) by snare technique

## Diagnoses & Procedure

- **Diagnoses**

- Screening Colonoscopy
- Polyps x 2
- Constipation

- **Procedure**

- Colonoscopy with polypectomy X  
2

## ICD-10 & CPT Coding

- Z12.11- Encounter for screening for malignant neoplasm of colon
- D12.4- Benign neoplasm of colon, unspecified
- K59.00- Constipation unspecified
- Procedure
  - 45385 33- Colonoscopy flexible with removal of tumor(s), polyps(s), or other lesion(s) by snare technique

- **Upset patient**

- Lack of screening diagnosis led to patient charged \$4K under high deductible plan
- EOB false signal; health record incorrect
- Proverbial Message- “Coded Incorrectly”
- Eligibility for benefits and/or cost to the patient may be affected
- Negative patient provider relationship





FAMOUS  
LAST WORDS



# Proactivity & Interdependence

- To Avoid consequences like this everyone plays a role in ensuring the integrity of the revenue cycle
- Interdependencies in the revenue cycle activities make collaboration and communication essential
- Be Proactive!!!

- If you see something say something
- Look for and recognize patterns
- Be on the alert
- If it doesn't seem right, it probably is not right
- One touch is preferred to multiple touches. Re-working a claim uses extra resources, raising the cost to collect
- Resources allocated to claim denial and resubmission draw resources for other collection activities, raise collection costs and slow collections





**Thank You**

**Questions?**





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