Revenomics 101

October 4, 2012
Location: Our Lady of Resurrection
A course designed for staff across the Revenue Cycle
### Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:00 AM - 8:15 AM</td>
<td>Introductions and General Information</td>
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<tr>
<td>8:15 AM - 8:30 AM</td>
<td>Program Outline: What You Will Learn and How it Will Benefit You</td>
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<td>Speaker - Patrick McDermott, Sr. Vice President</td>
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<tr>
<td>8:30 AM - 10:00 AM</td>
<td>Revenue Cycle: Part One - 1.5 CPEs</td>
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<td>Patient Access: Speaker, Eleanor Michalek; System Director Patient Access</td>
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<td>Financial Counseling/Charity Care: Speaker, La'Queela Angel; Director, Financial Counseling</td>
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<td>10:00 AM - 10:15 AM</td>
<td>Networking Break</td>
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<td>10:15 AM - 12:00 PM</td>
<td>Revenue Cycle: Part Two - 2 CPEs</td>
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<td>Revenue Integrity/ RAC / Clinical Denials: Speaker, Janice Wolfe; Corporate Director of Revenue Integrity, Presence Health</td>
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<td>Acronym Review</td>
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<tr>
<td>12:00 PM - 1:00 PM</td>
<td>Lunch and Networking</td>
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<tr>
<td>1:00 PM - 2:30 PM</td>
<td>Revenue Cycle: Part Three - 1.5 CPEs</td>
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<td>Vendor Management: Speaker, Patrick McDermott; Senior V.P.,</td>
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<td>Health Information Management/ICD-10: Speaker, Sandra Fuller; ICD-10 Project Mgr, Revenue Services Support,</td>
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<td>2:30 PM - 2:45 PM</td>
<td>Networking Break</td>
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<td>2:45 PM - 4:00 PM</td>
<td>Revenue Cycle: Part Four - 1.5 CPEs</td>
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<td>Billing, Collections/ Cash Posting: Speaker, Susan Pfister; System Director Revenue Cycle and Sandra Pauly; Director Underpayments and Denials</td>
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<td>Reporting/ Key Performance Indicators/ Applications: Speaker, Loretta Clifford; System Director Revenue Cycle, Presence Health – Provena</td>
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<tr>
<td>4:00 PM - 4:15 PM</td>
<td>Acronym Review</td>
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Just For Your Information

- After each speaker's section there will be time for questions.
- The Presence Health Logo 🌶️ means Questions Time!
- 50 Question in Course Review to Reinforce Learning
- Acronym Review sections are bonus sections!!
What You Will Learn and How it Will Benefit You

- A survey course to become fluent on the front, center, and back of the Revenue Cycle
- Hospital and Vendor, Directors and Managers can work together more effectively if they have a holistic view of the Revenue Cycle
- Common Objectives we ALL share:
  - Assist with *Denial and Bad Debt Reduction*
  - Improve *Customer Satisfaction* and Enhance *Physician Satisfaction*
  - Reduce *Re-work, defects, and non value-added*
The Revenue Cycle
"Assembly Circle"

- SCHEDULING AND PRE-REGISTRATION
- PRE CERT AND INSURANCE VERIFICATION
- REVENUE INTEGRITY / CHARGE CAPTURE
- Training/Support
- Quality Assurance
- Tools & Technology
- Recruiting
- Measurements/Monitor
- Revenomics
- Cash Posting
- Payment Review (Voucher Processing)
- Third Party Follow-Up
- Billing
- Medical Records Coding
- Case Management
- Financial Counseling
- Self Pay Collections
- Customer Service
<table>
<thead>
<tr>
<th></th>
<th>Fundamentals of a Highly Effective Revenue Cycle Manager</th>
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<tbody>
<tr>
<td>1.</td>
<td>Rounding with purpose/Huddles</td>
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<td>2.</td>
<td>High Risk Mitigation, e.g., census review to identify accounts not secured, which require intervention.</td>
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<td>3.</td>
<td>Training – Revenomics 101; Department formal training/apprenticeship/1st 90 day 100% QR.</td>
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<td>4.</td>
<td>Quality review/feedback on all staff with regular intervals.</td>
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<td>5.</td>
<td>Productivity standards/reporting by staff person.</td>
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<td>6.</td>
<td>Monthly scorecard on 6 “key” measures for success. Measuring to improve with weekly review of KPIs (Cash, Denials, AR/Aging, and registration related exception reports from each Host system); Visible metrics posted for staff.</td>
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<tr>
<td>7.</td>
<td>Talent roster maintained/updated monthly/development plan for your supervisors and leads.</td>
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<td>9.</td>
<td>Root Cause Analysis on each denied payment and service break-down.</td>
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<td>10.</td>
<td>AIDET+ and same day service recovery. Clear expectations with other departments on escalation protocol</td>
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<tr>
<td>11.</td>
<td>Preparation and contribution at accountability/leadership meetings (Hospital leadership meetings, monthly PA department meetings, RC meetings, FCC, technical denials meetings.)</td>
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<tr>
<td>12.</td>
<td>Motivating to create a highly engaged staff, e.g., save emails, pizza parties for new records, Gallup Q12 surveys, incentives, career ladders.</td>
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</table>
PRESENCE HEALTH
REVENUE CYCLE ORGANIZATION CHART

Patrick McDermott
Revenue Cycle Officer

Assistant

Patient Access
- 12 Patient Access depts: Admitting, ED, and OP areas. PH ministries have scheduling.
- CDM Maintenance; Pricing; Annual updates
- Central Scheduling/Pre-Registration/Pre service collection
- Physician Office assistance/ Concierge Services
- Coordination with patient care departments on preps/instructions/patient experience
- Insurance Verification/ Notification/ Authorization
- Financial Counseling at ministries and Financial Assistance application adjudication
- Point of Service Collection
- Service excellence/Patient Satisfaction improvement
- Cashiers
- Registration formal training and QA

Revenue Integrity & Clinical Revenue Cycle Improvement
- CDM Maintenance; Pricing; Annual updates
- Pharmacy CDM maintenance
- Charge Capture Audit
- Insurance Audits by Nurse Auditors
- RAC/MAC Defense coordination
- Clinical Denials and appeals

Patient Financial Services (Acute Care)
- Government Billing & Follow-up
- Commercial Billing & Follow-Up
- Underpayment/ Denials Management/ Payor Meeting Liaison
- Outsourced AR Vendor Performance & Installation
- Customer Service / Patient Payment Collection/ Bad debt collection
- Cash & Adjustment Posting/ Electronic Lock Box

Revenue Cycle Integration
- EPIC Revenue Cycle conversion coordination with Healthlink team, testing, risk mitigation
- Software Applications Support /Integration/Optimization; TRAC, ONTRAC
- Net revenue enhancement projects; monitor ROI
- Revenue Cycle process audit, standardization, rapid cycle improvement
- KPI Reporting/graph packages/AR diagnostics
- Staff training/certification
- Operations Coordinators/Revenue Cycle accountability meetings (ministry based)
- Best Practice R&D/ MAP award application
- Integrate “Continuum of Care Revenue Cycle” (sharing data, vendors, apps)
- Expected reimbursement calc; Coordinate with Finance on C/A modeling
- Medicare bad debt log
- IHA reporting

ICD 10 PMO
- Assessment and Planning
- Coder Training/Certification
- Communication
- Data Analytics; financial impact assessment
- Coordination with HIM/CDI functions
- Productivity technology selection
- Go-live readiness

Councils:
Revenue Cycle Strategy
RAC Council
ICD-10

4/20/12
Challenges specific to the Revenue Cycle/Finance

- RAC defense challenges our ability to work across the financial and clinical boundaries
- EMR installation challenges our ability to work across the IT, revenue cycle, finance and hospital operator boundaries
- ICD-10 requirement by Oct 2014 challenges our ability to work across almost every boundary
“I always thought of myself as a humanities person as a kid, but I liked electronics,” he said. “Then I read something that one of my heroes, Edwin Land of Polaroid, said about the importance of people who could stand at the intersection of humanities and sciences and I decided that’s what I wanted to do.

- Steve Jobs
Revenue Services: Enhancing Customer Experience with A.I.D.E.T.

- **A**cknowledge patient
- **I**ntroduce self to patient
- **D**redict **D**uration of time to complete service
- **E**xplain process
- **T**hank patient for choosing hospital
Revenue Services: Enhancing Customer Experience with A.I.D.E.T.

A.I.D.E.T. 30/5 RULE

– At 30 Feet Smile
– At 5 Feet Say Hello
– Revenue Services will be distinguished as the friendliest Division in Presence Health!
– Remember a smile is contagious!
– Once you have mastered the A.I.D.E.T. 30/5 rule you will see A.I.D.E.T. not only in your professional life but it will affect your personal life too!
Data from Patient Satisfaction Surveys is collected via HCAHPS (pronounced H-Caps) and used for collecting and publicly reporting information about patient experience of care that allows valid comparisons to be made across hospitals locally, regionally and nationally.

Patient Satisfaction measurements do not end at the time of discharge.

The patient’s experience is directly tied to all aspects of their stay including Revenue Services Functions.
Eleanor Michalek is the System Director, Patient Access for Presence Health, a 12 hospital healthcare system, also the largest Catholic healthcare system in Illinois. Resurrection Healthcare and Provena Health merged on November 1, 2011.

She has over 30 years experience in hospital financial operations. She has held various positions within the Revenue Cycle, as Director, Patient Financial Services, Regional Director, Revenue Cycle and Director, Patient Accounting. She centralized Insurance Verification at Provena Health and implemented standardization of Patient Access. She has served on the Board of Directors for First Illinois Chapter, HFMA and has also served as Chair, Revenue Cycle Committee.

Eleanor Michalek
System Director, Patient Access
Patient Access
The Foundation of the Revenue Cycle
“What you need to know about Patient Access!”

Patient Access in the Assembly Circle

The role of Patient Access

Patient Access Functions:
- Order Management
- Scheduling - Schegistration
- Pre-Registration
- Registration / Admission
- Financial Clearance
  - Insurance Verification (IV) / Precertification
- Financial Counseling
- Order Entry
- Point of Service Collections (POS)
- Financial Assistance Communication

Improve Customer Satisfaction with use A.I.D.E.T.!
Patient Access in the “Assembly Circle”
The Role of Patient Access

Patient Access is the foundation of the revenue cycle and the first impression of the hospital

Patient Access starts the access to clinical services
What Functions are Performed by Patient Access?

- Patient Access is responsible for several front-end functions, including:
  - **Order Management**
  - Outpatient Diagnostic **Scheduling (Schegistration)**
  - **Pre-Registration** of Scheduled Patients
  - **Registration** of Emergent, Urgent, Non-scheduled patients, and Recurring
  - **Financial Clearance**
    - Insurance Verification / Precertification of Scheduled and Admitted Patients
  - **Order Entry** of diagnostic tests (site specific)
  - **Point of Service Collection** of patient payments
  - **Financial Assistance Communication**
Patient Access Functions: Central Scheduling

Schedulers make appointments requested by patients and physicians.

Schedulers also PreRegister the patient during the scheduling encounter.
Order Management

• Screen electronic orders for required data
• Screen electronic orders for medical necessity
• Screen orders of non-staff physicians for OIG sanctions
• Return non-compliant orders and request required data
• Request additional diagnostic information on orders that do not meet medical necessity
• Initiate account creation in host system for patient to be scheduled
## Schegistration

### Outpatient Diagnostic Ancillary Services

- Contact patient to schedule
- Correctly interpret the physician order to be certain the service the patient receives is the service ordered
- Complete required screening questions prior to scheduling exam
- Schedule exam and provide patient with prep and arrival instructions
- Collect demographic and insurance information
- Verify that services ordered are medically necessary by comparing ordered procedure with physician-provided diagnosis
- Inform patient of current amounts due in addition to requesting payment of prior account balances
- Ensure that authorizations are secured
- Coordinate schedules with ancillary departments to ensure seamless patient encounter
- Notify physician when payor requires that authorization be initiated by them
Pre-Registration

Surgical and Interventional Procedures:

- Identify and prioritize scheduled patients based on procedure date
- Initiate contact with the patient to secure and collect demographic and insurance information
- On a daily basis identify procedures scheduled for the next week and ensure accounts are financially secured
  - Those that are not financially secured will be escalated to ensure completion prior to patient arrival
  - Self-pay patients needing to make a payment will be requested to stop at Patient Access to do so
- Create a forms packet for each patient and hand deliver to procedure areas
  - Helps to minimize patient wait times on the day of service
  - Patient can bypass Patient Access and proceed directly to the service area to check-in
Patient Access Functions: What Makes a “EXCELLENT” Registration?

Only the “Excellent” rating counts in our patient satisfaction scores

- Accuracy
- Timeliness
- Efficiency
- Complete and “Secure”
“EXCELLENT” Registration!

Excellence in Patient Access equates to improved financial outcomes and improved patient satisfaction scores.
Registration: Patient and Demographic Data

• During the patient interview, the Registrar is responsible for collecting and confirming patient demographic information, consisting of:
  – Legal Name
  – Date of Birth
  – Mailing Address
  – Phone Numbers (Home and Cellular)
  – Employer Information
  and
  – Next of Kin Information
Patient Access Functions: Registration/Billing Information

- Registrars are responsible for collecting and documenting information to facilitate prompt payment, including:
  - Identification and selection of the correct insurance plan
  - In the case of multiple insurance policies, correct sequencing of primary, secondary, and tertiary insurance
  - Entry of occurrence and condition codes related to the patient’s visit
  - Identifying self-pay patients, attempting to collect, and for those unable to pay, providing them with a financial assistance application.
Patient Access Functions:
Registration/Consequences of Entering Info Incorrectly

- Lost Reimbursement
- Denials
- Patient Safety
- HIPAA
- Red Flags
- Returned Mail
- Rework / Skip tracing
- Patient not informed of charges for services
- Duplicate Medical Records Numbers (MRN)
In order to comply with all federal and state requirements Registration secures patient signatures on legal documents and provides explanation of these notices and forms

- Health Information Portability and Accountability Act Privacy Notices
- Patient Bill of Rights
- Consent for Treatment
- Valid Physician Order
- Photo Identification to Comply with Red Flags
- Advanced Directives / Living Will
- Health Information Exchange (opt-out?)
- Medicare Secondary Payor Questionnaire
- Important Notice from Medicare
- Advanced Beneficiary Notification
Patient Access Functions: Registration/Documentation

Verify patient identity and insurance coverage and scan/copy patient’s personal ID and insurance cards.

Scan necessary forms such as “Consent Forms” etc.

Patient access places the arm band on the patient for their services in accordance with the National Patient Safety standards.

Registrars must enter a note on each and every account.
Financial Clearance

Many insurance companies require prior authorization for hospital services.

The Patient Access department starts this process by notifying securing authorizations for the proposed service.
Financial Counseling

Primarily focuses on the self pay population to:

- Collect payments and make payment arrangements

For patients with an inability to pay they:

- Screen for funding sources i.e. Medicare and Medicaid eligibility and other governmentally sponsored healthcare funding
Patient Access Functions: When is Insurance Verified?

Scheduled Patients:

- The standard is to complete insurance verification before the patient presents for service.

Non-scheduled Patients:

- In many cases the insurance eligibility is verified electronically during the registration process for patients who are non-scheduled (i.e. walk-in, urgent, or emergent).
Patient Access Functions: What Information is Verified?

An electronic work-driver is used for Insurance Verification (IV). We verify multiple pieces of information, including:

- When the patient became eligible for their insurance coverage and that the patient is eligible to receive the services on the (proposed) service date
- The amount of reimbursement expected; in turn this figure is used to estimate the patient’s out of pocket liability and review of prior balances
- Whether there is any restriction on the patient’s benefit i.e., Medicare / Medicaid converted to Health Maintenance Organization (HMO)
We also verify:

- For Health Maintenance Organization (HMO) validate the patient is eligible to receive services at our location
- Lifetime Maximum benefits on the patient’s policy and how much, if any, of this benefit has been exhausted
- For Medicare inpatients the number of days the beneficiary has available, at the beginning of their stay
- Where the claim is to be directed for payment

In addition to verifying information we:

- Refer patients with high dollar deductibles to Financial Counseling, and
- Notify case management when clinical precertification is needed
Patient Access Functions: How is Insurance Verified?

For most patients insurance is verified by:

- Accessing online systems
- Using payor websites to initiate authorizations, or
- By placing a telephone call to the insurance company.
- Electronically submitting the NOA for select payors.
Registrars are responsible for documenting medical information in the registration, including:

- Name of physician who ordered test or who will be treating patient
- Preliminary diagnosis (reason for test/service)
- Assigning the patient to the correct patient type/service type/location dependent upon the service provided
- Obtaining the name of the patient’s Primary Care Physician (PCP) and his/her contact information
Patient Access Functions: Point of Service Collection

In some cases, Registrars are asked to attempt to collect patient liabilities during the patient visit.

– For uninsured **Emergency Room (ER)** patients, after the patient is stable, the Registrar requests a minimum down payment.

– For insured **Emergency Department (ED)** patients with an identified copayment, the Registrar attempts to collect the copayment.

– In addition to these, if the patient has any open prior balances, those are requested
Patient Access Functions:
OP POS Collection

For self-pay outpatients, **Presence Health’s** policy is to collect minimum deposit amounts prior to the patient receiving services. Deposits are based upon the service type.

- The Registrar must know how to obtain prices for services in order to estimate charges and down payment.

- For elective services, if the patient is unable to pay, prior to the date of service the Registrar must contact their leader who will contact the patient’s physician to determine whether the service is urgent or whether it can be safely postponed.
Patient Access uses the term “securing an account” to describe the steps taken in order to be confident that we understand how the hospital will be reimbursed for its services.
<table>
<thead>
<tr>
<th>Patient Access Key Points</th>
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<tbody>
<tr>
<td>Greater Patient Satisfaction is achieved when patients can be scheduled and pre-registered</td>
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<td>Registrations which fully capture the patients information in order to eliminates re-work, returned mail, and facilitates the creation of a “clean claim”</td>
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<td>Obtain or scan necessary documentation to ensure that the entire revenue cycle has this information readily available</td>
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<tr>
<td>Meaningful documentation is essential to the Revenue Cycle process</td>
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<td>Point of Service collection reduces bad debt and the cost to collect</td>
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<tr>
<td>Using A.I.D.E.T is essential to meeting our expectations with our customers!</td>
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La’Queela Angel is the Director of Financial Advocacy, at Presence Health with responsibility for monitoring the inventory of accounts under Presence Health Financial Assistance / Charity Care policy or Medical Assistance No Grant (MANG) program and Revenue Service Cashiering functions. La’Queela Angel joined Resurrection Health care in 2004 as Manager of Patient Financial Services, with responsibilities for Billing, Collections, Insurance Verification, Financial Counseling and other key Patient Financial Service functions. Prior to joining Resurrection Health Care La’Queela Angel worked as a Consultant Manager for Recovery Programs, Case Installation Manager and Underwriting Supervisor at several companies, including Unicare formerly known as Rush Prudential, and The Tintari Group. La’Queela has a Bachelor of Arts Degree in Accounting from Indiana State University.
Financial Counseling
“What you need to know about Financial Counseling and Financial Assistance!”

- Financial Counseling and Financial Assistance in the Assembly Circle
- The Role of the Financial Counselor
- The In-House Interview
- Different Sources of Funding
- Financial Assistance/Charity
Financial Counseling in the “Assembly Circle”
The Role of the Financial Counselor

The Financial Counselor (FC) screens uninsured and underinsured patient accounts to:

1. Explore possible eligibility for sources to fund patient’s healthcare
2. Collect copays, deductibles, deposits, and coordinate payment arrangements
The In-House Interview

The Financial Counselor interviews the patient to:

- Evaluate if there are any possible reimbursement sources
- Collect known co-pays and deductibles
- Assess if the patient may qualify for Financial Assistance/ Charity Care
Different Sources of Funding

1. Medicaid (MANG)
2. Medicare (Social Security/Disability)
3. Commercial Insurances
4. Liability Insurance
5. Workers Compensation
6. Crime Victim Coverage
7. **COBRA (Consolidated Omnibus Budget Reconciliation Act)**
8. **Financial Assistance/Charity Care**
**Different Sources of Funding: Medicaid (MANG)**

- Medicaid - is a health care program funded by the U.S. Federal and State governments that pays the medical expenses of people who are unable to pay some or all of their own medical expenses which is ran by the Illinois Department of Healthcare and Family Services (HFS).
- People served by Medicaid are U.S. citizens or legal permanent residents, including low-income adults, their children, and people with certain disabilities.
- Poverty alone does not necessarily qualify someone for Medicaid. Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States. If an applicant is categorically eligible but has excess income and/or resources, they can qualify for Medical Assistance under the spend-down program.
- MANG – Medical Assistance No Grant (Persons who are categorically eligible for AABD (aged, blind, or disabled) or Temporary Assistance for Needy Family (TANF) (members of a family with dependent child) who do not receive cash assistance because of excess income or asset, but qualify for regular or spend down Medical Assistance No Grant.
Medicare is health insurance for the following:
- People 65 or older
- People under 65 with certain disabilities
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Different Parts of Medicare:
1. **Medicare Part A**
   Helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

2. **Medicare Part B**
   Helps cover doctor’s and other health care provider’s services, outpatient care, durable medical equipment, and home health care.
   Helps cover some preventive services

Financial Counseling applies for Social Security benefits for patients who potentially qualify for Medicare through the local Social Security Administration office.
Different Sources of Funding:
Commercial Insurance

Commercial Insurance is any type of health insurance that is not offered or managed by a government entity. Commercial health insurance companies are for profit corporations, and offer their insurance services through group insurance plans as well as individual or personal plans. In all situations, a commercial insurance of this type is available only to those who are willing to pay premiums in exchange for the coverage.

If it is determined during the screening process that the patient is unable to make his/her insurance premium; Presence Health will make the premium payment on behalf of the patient.
Different Sources of Funding: Liability

- If the patient is being treated for injuries or illness resulting from an accident, the FC explores whether any party can be held liable for the patient’s injury.

- It is important to identify a liability as quickly as possible – in these cases there is a need to file a lien to protect the hospital/medical portion of any settlement.
Different Sources of Funding: Worker’s Compensation

During the screening process Financial Counseling identifies any job-related illness or injury for which the patient’s employer may have financial responsibility.
Different Sources of Funding: Crime Victims

- Patients being treated for injuries received as a victim of a crime may be eligible for Crime Victim’s Compensation, a program which may pay medical bills for uninsured crime victims.
- All patients seeking Crime Victim’s Compensation must request Financial Assistance prior to any Crime Victim Compensation being paid.

NOTE: This program will NOT pay for any individual injured while perpetrating a crime.

Crime Victim’s Compensation is the payor of last resort.
Different Sources of Funding: COBRA

Patients that recently became unemployed, and were covered by a group health insurance policy, we explore whether the patient might be able to re-activate that group insurance program under **COBRA**.

**Consolidated Omnibus Budget Reconciliation Act** (*Not Coordination of Benefits!*)

If it’s determined during the screening process that the patient is unable to make his/her cobra premium; Presence Health will make the premium payment on behalf of the patient.

*
Different Sources of Funding:
Financial Assistance

The FC will provide the patient with a copy of the **Financial Assistance Application (FAA)**. This form is used:

- To inform the patient about documents necessary to validate and assess eligibility for Financial Assistance / Charity Care
- To calculate discounts due and to communicate eligibility determination to the patient
- To document of income information provided by the patient to be reviewed by the FC.
- To determine Presumptive Eligibility
- To calculate a Catastrophic Discount
The policy is designed to be fully compliant with applicable law, including the Acts listed below. In many respects, the Policy exceeds such legal requirements, reflecting our commitment to assuring that the poor and underserved have access to needed health care.
Federal Poverty Guidelines (FPG) are updated annually in conjunction with the published updates by the United States Department of Health and Human Services.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>2012 Federal Poverty Guidelines</th>
<th>200%</th>
<th>600%</th>
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<tbody>
<tr>
<td>1</td>
<td>$11,170</td>
<td>$22,340</td>
<td>$67,020</td>
</tr>
<tr>
<td>2</td>
<td>$15,130</td>
<td>$30,260</td>
<td>$90,780</td>
</tr>
<tr>
<td>3</td>
<td>$19,090</td>
<td>$38,180</td>
<td>$114,540</td>
</tr>
<tr>
<td>4</td>
<td>$23,050</td>
<td>$46,100</td>
<td>$138,300</td>
</tr>
<tr>
<td>5</td>
<td>$27,010</td>
<td>$54,020</td>
<td>$162,060</td>
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<tr>
<td>6</td>
<td>$30,970</td>
<td>$61,940</td>
<td>$185,820</td>
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<tr>
<td>7</td>
<td>$34,930</td>
<td>$69,860</td>
<td>$209,580</td>
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<tr>
<td>8</td>
<td>$38,890</td>
<td>$77,780</td>
<td>$233,340</td>
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<tr>
<td>9</td>
<td>$42,850</td>
<td>$85,700</td>
<td>$257,100</td>
</tr>
<tr>
<td>10</td>
<td>$46,810</td>
<td>$93,620</td>
<td>$280,860</td>
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Presumptive Financial Assistance Eligibility

Presumptive eligibility may be determined on the basis of individual life circumstances. In these situations, a patient is deemed to be eligible for a 100 percent reduction from charges (i.e. full write-off.) A patient is presumed eligible and therefore does not need to complete a financial assistance application when sufficient evidence is provided that they meet one of several criteria.

When a patient does not complete an application and there is adequate information to support the patient’s inability to pay, these cases will be submitted to the ministry’s FAC for approval. If approved, 100% write off to financial assistance will be granted for all open accounts. Assistance will NOT be granted for future dates of service.
A “Catastrophic” case is defined as a circumstance in which after application of the charity discount amount, the remaining out of pocket liability exceeds 15% of the family’s annual income as determined during the Financial Assistance Assessment. In order to qualify as a catastrophic case, the patient must qualify for some level of the charity discount under the Presence Health Financial Assistance policy.

Some insured patients are also eligible for a Catastrophic discount. If the patient’s balances after insurance exceed 15% of the family’s annual income, and the patient qualifies for some level of the charity discount under the policy, they fall under the criteria for having a catastrophic case.
Who Qualifies for Financial Assistance / Charity Care?

Financial Assistance/Charity Care is based on family size and income according to the Federal Poverty Guidelines (FPG). In addition to the family size and income requirements the following must be provided:

- They have received a medically necessary hospital service
- They have cooperated with efforts to qualify for reimbursement sources such as Medicare / Medicaid
- They are able to provide documentation of household income and family size
- They currently reside in the given state, or
- Have catastrophic medical expenses
When the FCs have completed their review, they make a decision (called a “determination”) regarding the patient’s eligibility for Financial Assistance/Charity Care. There are three possible determinations:

- Approved
- Not Approved
- Undetermined/ Need Info
Approved

Individuals approved for financial assistance will receive a letter informing them of the approval as well as the percentage of assistance received.

The letter will also inform the individual of the remaining balance after the financial assistance has been applied.

Remaining balances will be treated in accordance with the Patient Financial Services policies regarding payment arrangements. If a patient is unable to meet the payment arrangement guidelines, the Revenue Cycle Representative may review and recommend additional financial assistance to the ministry Financial Assistance Committee.
Not Approved

A prompt turn-around and written decision, which provides a reason(s) for denial (if appropriate) will be provided, generally within 45 days of the ministry’s Financial Assistance Committee’s decision after reviewing a completed application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

If a patient disagrees with the decision, the patient may request an appeal process in writing within 45 days of the denial. The ministry’s Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within 45 days, and reflect the Committee’s final and executive review.
Undetermined/ Need Info

Undetermined status describes those cases for which the patient did not provide documents requested to validate their income/family size; consequently, the FC was unable to determine their eligibility.

This determination closes the application but the patient may request an assessment at any time.
Right to Appeal

Patients who are denied financial assistance will be sent a letter within 45 days of receipt of the application.

This letter will provide information as to other options available, including the ability to appeal the decision by requesting a Supplemental Appeal form.

The appeal form will be provided to the patient upon request and has to be returned within 45 days of the receipt.

Appeals will be reviewed by the FAC, and the FINAL EXECUTIVE DECISION will be communicated within 45 days.
Exceptions

The FAC will consider patient accounts on a case-by-case basis that are exceptions to the eligibility criteria on a monthly basis.

The committee will consist of the hospital Chief Executive Officer, Chief Financial Officer, VP Mission Services, Revenue Integrity Director (or designee), Director of Case/Care Management, Patient Financial Counselor or a similar mix of individuals for the ministries. The committee has the authority to approve/reject any requested exceptions to the Provision for Financial Assistance policy based on unusual or uncommon circumstances.

All decisions, whether approved or rejected, must have the rationale clearly and formally documented by the committee and maintained in the account file.

Decisions reached will be communicated to the patient within 45 days, and reflect the Committee’s final and executive review.
Oversight

All approved Financial Assistance Applications must be reviewed prior to posting adjustments to accounts.
Other Routes to Financial Assistance/ Charity Care

Our patient statements include a message asking the patient to contact Customer Service if they think they may have difficulty in paying their hospital bill.

www.presencehealth.org

www.provena.org

www.reshealth.org
Other Discounts

Automatic Uninsured Patient Discount
A discount in the amount of 40% will be provided to all uninsured patients without regard to income or ability to pay for all medically necessary services.

If an insured patient’s coverage is exhausted, the patient will be considered uninsured for the purposes of financial assistance and the automatic uninsured discount will also be applied.

There is no application process for the patient to receive self-pay discount. The discount is applied based on the account’s self pay status.

Patients receiving pre-negotiated discounts (package pricing) will not be eligible for the automatic uninsured discount.

If a patient is subsequently approved for charity, the automatic uninsured discount will be reversed and the charity allowance will be applied.
Package Pricing

- Uninsured patients may also receive “package rates” for some scheduled procedures.
  - This discount method is most frequently used for obstetric and elective plastic surgery patients
  - Not eligible for other discounts
Key Points: Financial Counselor/Financial Assistance

Presence Health provides a 40% uninsured patient discount to all Self-Pay Patients for medically necessary service.

Capturing complete demographic / insurance data provides essential information to the Financial Counselor and is an asset to our reimbursement process.

Intervention by a Financial Counselor is a fundamental tool which can:

- Facilitate payment for the Presence Health
- Build a positive relationship between Presence Health and the community
Robert Hanley, Director, Revenue Integrity

Rory is the System Manager of Revenue Integrity at Presence Health, focused on CDM Maintenance and Charge Capture activities for twelve hospitals. Rory has been in the role of System Manager of Revenue Integrity for two and a half years and served as Senior Operations Liaison for Presence Health’s St. Joseph Chicago and Saint Mary’s and Elizabeth Medical Center prior to moving to Revenue Integrity. Before joining Presence Health, Rory worked in Revenue Cycle Consulting for over 12 years with several firms including, McKesson Corporation, Stockamp and Associates, and Shared Medical Systems. Rory holds a Master of Health Administration from Indiana University and Bachelor of Arts from DePaul University.
Revenue Integrity
Charge Master
Charge Capture
RAC Denials
What you need to know about Revenue Integrity

- Revenue Integrity in the Assembly Circle
- The Revenue Integrity Structure
- Charge Description Master
- Annual Price Updates
- Charge Capture Audits
- IT Applications
- RAC Denials
- Definitions
Revenue Integrity in the “Assembly Circle”

- Scheduling and Pre-Registration
- Pre-Cert and Insurance Verification
- Registration and Point of Service Collection
- Financial Counseling
- Recruiting
- Training/Support
- Quality Assurance
- Tools & Technology
- Revenue Integrity / Charge Capture
- Revenueomics
- Measurements/Monitor
- Cash Posting
- Payment Review (Voucher Processing)
- Third Party Follow-Up
- Billing
- Medical Records Coding
- Case Management
- Customer Service
- Self Pay Collections
- Billing
- Third Party Follow-Up
- Revenue Integrity in the “Assembly Circle”

Presence Health
Revenue Integrity Team

**Offense**
- CDM Manager
  - Project Management
- CDM specialists
  - Coding
  - Pharmacy
- Charge Capture
  - Nursing
- Insurance Defense Audits
  - BLS

**Defense**
- Clinical Denials Manager
  - UR/CM Compliance/Law
  - Data Analyst
- Clinical Denial Analyst
  - Site Based Nurses
- Clinical Resource Center
  - Nurses
- E.H.R.
- Convergent
Charge Description Master

CDM: Charge Description Master

- Each Hospital has its own CDM
- Each CDM is made up of individual charge codes
- In Epic the CDM is called the EAP.
- Industry standard is CDM
A **charge code** is the number assigned to a service or supply. Each **charge code** is embedded with an appropriate CPT or HCPCS code, UB code and price for billing.

**What does CPT and HCPCS stand for?**
- **CPT** (Current Procedural Terminology)
  - Published by AMA
  - Updated Annually
- **HCPCS** (Healthcare Common Procedural Coding System) Code
  - Letter followed by 4 digit number
  - Updated Annually

**What is a UB Code?**
- **UB (Universal Billing) code**
- Revenue Code
- Generally represents the type of service
- Examples: 450 is the UB code for the Emergency Dept.
CDM Pricing

The CDM is used primarily for outpatient procedures.

Medicare reimbursement is based on Ambulatory Payment Classification (APC).

CDM Prices should follow a standard pricing policy.
- Example: Based on 2X Medicare, % over cost, not to exceed
- 50-75% of competitors

CDM Prices are updated annually on July 1.

CDM Price increases are limited by contractual agreements with payors.
How do you think CDM pricing might affect a self-pay customer?

If a customer asked for the price of a procedure in May and then came to have the procedure in July--Would the price be the same?
“Hard Coded”: The **CPT** or **HCPCS** code is embedded in the charge code. Examples:

- Chest x-ray:
  - CPT 71020 Chest x-ray front & lateral
- Laboratory test:
  - CPT 85027 Complete Blood Count (CBC)

“Soft Coded”: Coded by Medical Records/Health Information Management (HIM). Example:

- Surgery Revenue Code 360

Coding depends on the physician documentation

- Hernia Repair
- 37 codes
The ABC’s of Patient Charge Process

A  Account
Patient Access Creates the account

B  Begin
And Completes the service

C  Charge
The performing department charges the account

D  Department
Reconciles the account to make sure the charges are correct
Charge Master Audits

Charge codes must be accurate in the CDM.

Incorrect codes in the CDM creates billing re-works and denials.

Accounts must be reconciled daily for accuracy in charging.

Charge audits help to identify errors.

Examples of CDM coding error:
- CT abdomen & pelvis-CT angio
CDM Software Applications

• CDM Integrity
  – How clean is the CDM?
  – Monthly reports of CDM integrity.
    • No deleted CPT codes
    • No revenue code mismatch

• Charge Capture
  – Software to identify potential missed revenue. Examples:
    • Hernia repair with Mesh CPT 49568+ add on
      – Software to identify base code 49560 hernia repair
    • Chemotherapy infusions CPT 96423+ add on
      – Software looking for base code 96422
    • Blood product missing blood transfusion
      – P9021 missing CPT 36430
How Good is Good Enough!

What can one simple error mean?

1,000,000 visits x 1% = 10,000 errors

10,000 x $500.00 = $5M in Losses!
Recovery Audit Contractors (RAC)

RAC Review
2008-09 RAC Demonstration Project limited scope
2010 RAC Permanent Implemented
Since inception CMS reports $2.6B in incorrect payments
Cardiovascular procedures done in the incorrect setting #1

RAC Update
August 27, 2012 RAC Prepayment Demonstration Project
   Eight Targeted DRGS: Starting with: 1. Syncope  2. TIA
   Seven HEAT States: Illinois (Chicago) one of the HEAT states
   Healthcare fraud Enforcement Action Taskforce
Denial Audit Strategies Council Structure

Denial Audit Strategy Council members

- Co Chair, SVP Revenue Services
- Co Chair Vice President, Professional Services
- Co Chair System Director Revenue Integrity
- Manager, Compliance
- System Vice President, General Accounting
- System Director, Reimbursement
- Manager Clinical Process Improvement
- Vice President, Case Management
- Vice President, Chief Medical Officer (Physician Champion)
- Director HIM
- Manager, Clinical Decisions and Support
- External Audit Manager
- Clinical Denial Nurse
- System Manager Clinical Documentation
- Manager PFS Compliance
- Coordinator Performance Distinction Information Systems

Denial Audits Strategy (RAC) Council acts as Guiding Body

Clinical Denials Analysts/Centralized Clinical Resource Center

Response Platform

Medical Record Duplication/HealthPort

Case Management and Executive Health Resource (E.H.R.)

InterQual Criteria and MIDAS Case Management System

Charge Capture and Charge Master Maintenance

Clinical Documentation Improvement Program
8366 Medical Record Requests for Complex Denials
- 3645 Coding reviews for DRG validation (44%)
- 4512 Medical Necessity reviews (54%)
- 209 Billing issue reviews (2%)

4876 No denial issued from medical Record Review (58%)
- 1280 Pending RAC (CGI) review (15%)
- 25 Reversal of overpayment accounts
- 18 Discussion overturned with no demand
- 6 Rebilling recovery with no demand
- 2116 Denials issued by RAC (CGI) (25%)

Appeal/Wins
- 164 out of 168 Discussions won (98%) CDA
- 202 out of 284 Level 1 Appeals won (71%) CDA
- 7/7 “Level 1 EHR Appeal won (100%) EHR
- 17/84 “Level 2 QIC Appeal won (20%) CDA
- 12/14 “Level 2 EHR Appeal won (86%) EHR
- 5/5 “Level 3 ALJ Appeal won (100%) EHR

Appeal Dollars Won
- Full Recover from Complex RAC Appeals $2,516,908
- Partial Recovery Complex Rebilling (96 cases: inpatient stay was not medically necessary and within timely filing rule) $128,850
- Underpayment Recovery (50) $174,316
- Automated RAC Denials recovery $212,684

Total Recovery from Appeals, Re-billing and Underpayments $3,032,758

Appeals Lost or Not Appealed
- Complex RAC denial write-offs Not Appealed (499) $2,573,185
- Complex RAC denial write-offs Lost in appeals $1,033,102
- Automated Denials (Billing rule violations) $131,844 (678) Automated RAC denial write-offs

Total RAC Loss $3,738,131

$6,710,906 Refunded (in process outcome not final)

Numbers based on RHC Midas Reports & Provena Midas Reports
Denials Appeal Success!

- **RACTrac**
  - AHA Survey tool shows that hospitals are appealing 40% of denials
  - When they appeal, hospitals win 70% of the time

- **Presence Health**
  - Appeals >70% of denials
  - Wins >70% of our appeals
  - E.H.R. wins 100% at the Administrative Law Judge level III
How do we handle those cases that potentially cannot be appealed?

Policy on when a case potentially cannot be appealed

- Three levels of review prior to decision not to appeal
  - Clinical Nurse review
  - Clinical Denials Committee (Site Based) or Revenue Cycle Meeting
    - Case Management, Coding, UR Physician
  - Hospital CFO
- Root Cause Analysis (RCA)
- Completed by Department Responsible for Denial
  - i.e. Coding, Case Management
- Root Causes are tracked and trended
- Root Cause Analysis Reviewed at Denial Audit Strategy Council
- Process Improvement Projects defined based on data from RCA
Operational Leadership Support

Root Cause Analysis
- Help move the solution forward to reduce the risk for denial; Examples:
  - Physician Education
  - PCI level of care tool
  - Standardized physician orders for ESA drugs

RAC Pre-Payment Denials Prevention Plan
- Education for ED physicians on short-stays for targeted DRGs
- Education for Case Management on Interqual
- Education for Clinical Documentation on physician Queries for targeted DRGs
RAC Update on ALJ Ruling

- Level III appeal
- CMS Agrees to abide by ALJ partially favorable ruling
- ALJ denies inpatient reimbursement but directs payment for Part B services or Observation Care
- Within 30 calendar days of receipt of the effectuation notice Contractor shall contact the provider to get a replacement claim
- Bypass the timely filing rule
- If no replacement claim is received in 180 days, the contractor may close the case.

Administrative Law Judge Ruling July 13, 2012
Revenue Integrity Key Points

- CDM accuracy
- Department Charge Reconciliation
- Charge Capture audits and software used to identify opportunities
- RAC focus on denial data
- Prepayment Denial Prevention plan
- RCA for Process Improvement planning
# Acronyms and Meanings

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>MEANINGS</th>
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<td>APC</td>
<td>Ambulatory Payment Class</td>
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<td>RAC</td>
<td>Recovery Audit Contractor</td>
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<td>RCA</td>
<td>Root Cause Analysis</td>
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</tbody>
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Previously, Patrick was the Revenue Cycle Executive for Health Alliance in Cincinnati, OH, an 8 hospital system. Patrick’s career started with consulting firms Stockamp & Associates and KPMG Peat Marwick. With Stockamp & Associates, Patrick was a Senior Manager in charge of implementing Stockamp’s proprietary revenue cycle solution.

Patrick is on the Board of Directors for HFMA First Illinois Chapter. He has served as an advisor for American Hospital Association’s (AHA), was a member of 2006 HFMA’s Consumer Directed Healthcare taskforce, is a previous Board of Examiner for the Ohio Partnership for Excellence, and is a regular speaker for the HFMA, World Research Group, and American Collectors Association.

Patrick received his M.B.A in Finance from University of Illinois.
Vendor Management
What you need to know about Vendor Management

- Vendor Management and the “Assembly Circle”
- The Importance of Vendor Management
- Philosophy: vendor operates as a “department down the hallway”
- Keys to Success
- Structure at it’s best
Vendor Management in the “Assembly Circle”
The Importance of Vendor Management

Active Vendor Management vs Passive Vendor Management

Delivered Returns
Keys to Successful Vendor Management

Top 10 Keys to Active Management

1. Reporting which is state of art
   - Data warehouse which can be queried by any data point
   - “Executive friendly” - Color coded Dash Boards
   - Drill Down ability on exception cases
   - Tracks the Return on Investment (ROI) from program start

2. Quality assurance system
   - Due Diligence is agreed upon at program start
   - Each staff person is audited at regular intervals

3. Service-Level Agreement
   - SLA is established before Go-Live
   - Escalation procedure: Same Day Service Recovery is the goal
Keys to Successful Vendor Management cont.

Top 10 Keys to Active Management (Cont.)

4. Stratification

• Differential strategies for different populations
• Entire population is managed (not “Cherry-Picked”)

5. Methodical, efficient start-up process

• Start-up packet reviewed at go-live meeting

6. Documented methodology (hiring, training, scripting)

• Formal procedures or scripting
• “Business rules” at the heart of powerful software engine

7. Reconciliation controls: “black holes” are identified

• Unassigned accounts are ID’d early
Top 10 Keys to Active Management (Cont.)

8. Point person is established, accessible, proactive
   - Point person has ownership
   - “Account rep” participates in “status meetings”
   - Industry expertise

9. Investment in technology is apparent, progressive, ahead of the client
   - Technology should lower cost of collection

10. The service is upgraded on regular intervals
Sandra R. Fuller, MA, RHIA, FAHIMA, is currently the Senior Vice President and Executive Consultant at eCatalyst Consulting. She is leading the ICD-10 Project Management Office for Presence Health the largest Catholic healthcare system in Illinois. Sandra is also adjunct faculty at Resurrection University in the Health Information Management program. She was the Executive Vice President and Chief Operating Officer at AHIMA where she lead the professional and membership facing services of the Association. Prior to joining AHIMA she was the Director of Patient Data Services at the University of Washington Medical Center. She served on the Board of Directors of AHIMA and was the President of the Washington State Health Information Management Association. She was awarded the WSHIMA Professional Achievement Award in 1996. She authored the book *Secure and Access Guidelines for Managing Patient Information*, published in 1997 by AHIMA.
Health Information Management/ICD-10
Objectives

– Introduce HIM’s role in the revenue cycle
– Discuss the link between documentation and reimbursement
– Highlight the coding challenge
– Introduce the change to ICD-10 and build awareness of the revenue cycle implications
H.I.M. in the “Assembly Circle”
HIM’s Role

On Admission
- Review admission order

During Hospitalization
- Recommend clinical documentation improvements

At Discharge
- Assign codes and determine DRG

Claims Processing
- Provide record information as required by payors

At Audit
- Review coding to determine appeal status

Ongoing
- Analyze case mix data
Documentation and Reimbursement

- POA
- HAC
- Diagnoses
- Procedures
- DRGs
- Data abstraction

Case Mix Index

- Claims
- Data warehouse
- Quality measures
- Meaningful use

Documentation

Codes & DRGs
The Coding Challenge

Faster

Better

DNFB

CMI
ICD-10 Introduction

ICD-10 At a Glance

What?
- Regulatory mandate to replace the International Classification of Diseases (ICD-9) with ICD-10

Who?
- All of Presence Health
- Clinicians – requires increased documentation specificity
- Coders/CDI specialists – completely replaces the system they use
- Revenue cycle staff – process claims
- Data users – impacts almost all of the organization’s reporting
- IT staff – impacts multiple clinical, business and reporting systems

When?
- October 1, 2014 – Final
On October 1, 2014 every bill must contain an ICD-10 code.
What Changes?

- **Hospital Inpatients**
  - ICD-10-CM
  - ICD-10-PCS

- **Hospital Outpatients**
  - ICD-10-CM
  - HCPCS
  - CPT

- **LTC, Hospice and Home Health**
  - ICD-10-CM
  - CPT
  - HCPCS

- **All Other HIPAA Entities**
  - ICD-10-CM
  - CPT
  - HCPCS

The only place that ICD-10-PCS is used

Everyone changes to ICD-10-CM
How They Compare

ICD-9

- V54.11, Aftercare for healing traumatic fracture of upper arm
- 50.11 Closed (percutaneous) [needle] biopsy of liver
- General codes – pick the closest one
- Familiar

ICD-10

- S42.302D, Unspecified fracture of shaft of humerus, left arm, subsequent encounter for fracture with routine healing
- 0FB13ZX Excision of right lobe of liver, percutaneous approach, diagnostic
- More information = less memorization
- Logic based coding
Benefits of ICD-10

- **Fair Payment**
  - Outdated
  - Out of space
  - Lacking detail

- **Leverage Technology**
  - More structured data
  - Computer-assisted coding

- **Measure Quality**
  - New demands on data
  - Increased specificity

- **Global Comparisons**
  - Epidemics/bioterrorism
  - Speed of transmission
# HIM Acronyms

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<tr>
<td>HIM</td>
<td>Health Information Management</td>
</tr>
<tr>
<td>ICD-10</td>
<td>International Classification of Diseases -10th Edition- Procedure Coding System</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnostic Related Group</td>
</tr>
<tr>
<td>POA</td>
<td>Present on Admission</td>
</tr>
<tr>
<td>HAC</td>
<td>Hospital Acquired Condition</td>
</tr>
<tr>
<td>CMI</td>
<td>Case-Mix Index</td>
</tr>
<tr>
<td>CDI</td>
<td>Clinical Documentation Improvement</td>
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Susan Pfister is the System Director, Patient Financial Services for Presence Health. Presence Health, a 12 hospital healthcare system, is the largest Catholic healthcare system in Illinois. Susan has over 20 years of healthcare experience and has held leadership positions in all areas of the revenue cycle. Susan has a Bachelor degree in Healthcare Administration and is a member of HFMA.

Sandra Pauly, MT(ASCP) is the Director of Underpayments (Variances) & Denials for Presence Health, a 12 hospital healthcare system, also the largest Catholic healthcare system in Illinois. Resurrection Healthcare and Provena Health merged on November 1, 2011. Sandy joined Provena Health in 2009. She developed the Technical Denials Unit at the Central Business Office and works in tandem with our ministry Clinical Denials team across the system. Prior to joining Provena Health, she has held various leadership roles in both Patient Financial Services and Laboratory Medicine at a large academic medical center, developing business operation process improvements for both the Laboratory and PFS. Sandra holds a BA in Biology from Augustana College and a BS in Medical Technology from Northwestern University.

Susan Pfister, System Director Patient Financial Services
Sandra Pauly, MT (ASCP), Director Denials and Underpayments
Patient Financial Services
PFS in the “Assembly Circle”
### “What you need to know about Billing and Insurance Follow-up!”

- Patient Financial Services – Virtual Business Office
- Key Functions of PFS
- Billing Goal / Basic Terms
- Patient Accounts in an Unbilled Status
- Patient Accounts in a Final Billed Status
- UB04
- Claim Edits
- Collections
- Cash Posting
- Payment Verification/ Denials
Key Functions of PFS

- Billing and Collections
- Cash Applications
- Payment Review
- Denials
- Refunds
- Customer Service
- Vendor Management
<table>
<thead>
<tr>
<th>Revenue Services: Billing Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> ✧ To produce a ‘clean claim’ the first time; to eliminate rework in order to receive timely and accurate reimbursement. ✧</td>
</tr>
</tbody>
</table>
Billing Basics
Revenue vs. Reimbursement

Revenue
The total charges placed on an account.

Reimbursement
The total dollars we expect the payor to pay.

Contractual Allowances
The dollars adjusted off an account based on the contract we have with the payor.

Denials or Write-Offs
The dollars we write off that were not collectable due to a failed process.
Billing Basics
Patient Liabilities

Deductible
Set dollar amount to be paid by the patient prior to insurance company making any payments.

Copayment
Set dollar amount to be paid by patient each time service is provided.

Co-Insurance
Percentage of payment to be made by the patient for services provided.

Non-covered
Services payable due to exclusions from patient’s policy.
Unbilled Accounts

Bill Hold or Suspense: Accounts are unbilled from the point of discharge until all bill requirements are met. Typically, day of discharge plus 3 days. During this suspense period:
- Charges are captured
- Medical Records Coding is completed
- Front End Edits are resolved

The majority of these edits must be resolved by front end staff:
- Patient Access
- Ancillary Departments
- Case Management

Claim will not move to final bill until edits have been resolved
Types of Unbilled Account Errors

• Demographic Errors
  – Wrong Insurance
  – Incorrect subscriber information

• Charge related Errors
  – Missing Modifiers
  – Local Coverage Determination (LCD) denials
  – Date of Service Errors
Once all Billing requirements are met and the suspense period has passed, the account moves from an Unbilled status (UB) to a Final Bill (FB) status.

During this transition from UB to FB the contractual adjustment is posted to the account based on contract terms, leaving the expected reimbursement as the account balance.
Final Billed Accounts

• Claims go through 2 sets of claim edits:
  • Within the host system
  • Within the electronic claims scrubber

• Both sets of edits evaluated against industry, payor, and customized billing edits

Creating and implementing customized edits provide a great opportunity for compliant claim submission and timely payment.
Resolving Claim Edits

Certain claim errors can be resolved by PFS, others require review by ancillary departments or clinical staff.

Errors requiring front end review are returned to the hospital.

At any one of the edit points, if the correction needed is clinical in nature, only a clinical person can authorize the change. **Billers are NOT authorized to make these decisions.**

Once claim errors are resolved the claim can then be submitted to the payor.
## Claim Form Overview – Sample UB04

### Patient Information
- **Name:** John Doe
- **Address:** 1234 Main Street, Philadelphia, PA 19111

### Claim Details
- **Service Provider:** Independence Blue Cross
- **Service Type:** Secondary Payer
- **Service Code:** 0129, 0250, 0360
- **Service Description:** Semi-Private, Pharmacy, OR Services
- **Amount: 200.00**

### Diagnosis Codes
- **Code:** A1
- **Description:** Value Codes and amounts required when necessary to process claim
- **Amount:** 952.00

### Payment Information
- **Provider:** Watch Repair, Inc.
- **Amount:** 222222222

### Additional Information
- **Doc. ID:** 491234
- **Date:** 11/03/06
- **Time:** 11:03

---

**Note:** The information is preliminary and may require further clarification or correction.
Collections

A work driver is used to stratify and prioritize the collector’s work.

The type and timing of follow-up is determined by multiple factors including the following:

- Payor
- Age
- Dollar amount

Types of follow-up can include:

- Telephone
- On-line (FSSO), Passport (NEBO), or Payor
- Batch Statusing
Cash Posting: How Payments are Received

All payments are posted by the cash posting team

Exception: POS payments taken at the facility.

• How payments are received:
  – EFT: Electronic Funds Transfer
  – Lockbox: Payments go directly to the bank, bank sends us Explanation of Benefits (EOB’s) for posting to the account

• How payments are applied
  • 835 File (payer created by lockbox)
  • Scripting into Cash Posting System
  • Manual by Cash Poster
Valuable Information Included with Payments

- Payor Considered Covered Charges
- Expected Reimbursement
- Denial Information
  - Claim Level
  - Line Level
- Patient Liability
Payment Verification

Payment review is vital to determine:

• Why did I not get paid ($0.00)?
• Why did I only receive a partial payment?
• Was the payment I received correct?
Payment Delays vs. Underpays vs. Denials


- Although there is some lack of industry standard use, payors do use **Claim Adjustment Reason Codes** (CARC) codes on their EOB’s (835 and paper) along with payments to identify reasons for payment and non payment.

- Providers should use these codes to drive process flow and **Key Performance Indicator** (KPI) reporting.
Payment Delays

Payment delay: You received a $0.00 or reduced payment. Why?

Payment is delayed due to a billing error that needs resolution or because the payor is requesting additional information to adjudicate the claim.
### Payment Delay

<table>
<thead>
<tr>
<th>Payment Details</th>
</tr>
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<tbody>
<tr>
<td><strong>Claim Level Adjustments</strong></td>
</tr>
<tr>
<td><strong>PR : 27</strong></td>
</tr>
<tr>
<td><strong>PR : 27</strong></td>
</tr>
<tr>
<td><strong>PR : 27</strong></td>
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</tbody>
</table>
Underpayments

Underpayment (or Variance):
Payor paid LESS or MORE than the contractual obligation as outlined in the Providers contract. The Explanation of Benefits shows all services as COVERED.

- Contract Interpretation
- System contractual rules are wrong or need adjustment
- Some services are included in payment for others.
- Submitted bill was missing elements
- Payor audit
Denials

Denials: Services I expected to get paid for but didn’t

Clinical Denials – Medical necessity and/or Non-covered, etc.

Technical Denials – Administrative type of denials such as missing authorization, timely filing, etc.
Appeal Process

• Appeal all clinical and technical denials for payment whenever possible.
• Failed appeals or denials that cannot be appealed result in a write off.
• Decide if your write offs are at gross/net
• Create a process to report write offs back to the accountable party (Patient Access, Case Management, PFS, etc.)
• Require response / summary for process improvement from those that are accountable.
• Establish Ownership
What We Do in Customer Service!

• We answer incoming phone calls from patients, insurance companies, attorneys, and other callers using the A.I.D.E.T. process

• Calls received include:
  – Charge inquiries
  – Complaint calls
  – Additions and Updates to Insurance Information
  – Questions regarding claim payment status
  – Set-up payment plans
  – Re-bill insurance
  – Financial Assistance
Self Pay Collections in AR

- Utilize Extended Business Office (EBO)
  - Initiates outbound calls to patients
  - Takes inbound customer service calls from patients
  - Updates demographic and insurance information
  - Communicates with patient regarding financial assistance availability.
Service Recovery on Complaints

• **Root Cause Analysis (RCA)**
  – How could this complaint have been avoided?

• Apologize to patient

• Identify new process to avoid repeat of this type of complaint in the future

• Log it!
What We Learn from our Patients

• Ways to improve the patient experience and provide excellent services
• Process improvement opportunities
• Training needs of our staff
• What we are doing well!
Key Points of PFS

• All edits both front end and claim edits need to be worked daily

• Clean claims are MANDATORY for payment

• Collections should be:
  ✓ Stratified
  ✓ Efficient, and
  ✓ Timely

• Posting accuracy with standard remittance codes

• Having a team in place to validate and review claims payment is Best Practice!

• Learn process improvement opportunities from our patients
Loretta Clifford is the System Director, Revenue Cycle Integration for Presence Health, a 12 hospital healthcare system in Illinois. Resurrection and Provena merged on Nov 1, 2011. She has over 25 years of experience in Healthcare in Revenue Cycle. As the System Director of the Revenue Cycle she orchestrated the development of the Centralized Billing Office in Bolingbrook. Loretta is a Registered Nurse and a CPA. Her nursing career was primarily in critical care at Elmhurst Memorial Hospital. While working as a nurse, she completed her degree in accounting and became a CPA. She worked in public accounting for Coopers and Lybrand. She has also held various positions as a Healthcare Consultant, Director of Internal Audit, Director of Financial Reporting, and an Administrative Director of Patient Financial Services at various hospitals including Hines VA, Michael Reese and Edward Hospital.
Seeking Excellence Through Key Performance Indicators
“What you need to know about Revenue Service Performance Indicators”

Performance Analysis in the Assembly Circle

- Scheduling, Pre-Registration, and Insurance Verification
- Financial Counseling
- Point of Service Cash Collections
- Billing and Collections
- Health Information Management
- Denials

Hitting the “Bulls Eye”

Monthly Performance Analysis
Monitoring Performance in the “Assembly Circle”
Multiple strategies are required to hit the “Bulls Eye”
Scheduling Measurements

Number of calls

Disposition of calls

- Was it answered?
- How long did it take to answer the call?
- Did they hang up before the call was answered?
- What percentage of calls were abandoned after waiting 30 seconds?
Scheduling

Stockamp, A Huron Consulting Group Practice (Stockamp)
Revenue Cycle Solution at Resurrection Health Care
Central Scheduling Monthly Performance Scorecard

TREND GOALS:
▼ Abandonment Rate
▼ PR at Scheduling

HFMC Facility Central Scheduling Monthly Scorecard

<table>
<thead>
<tr>
<th>HFMC</th>
<th>Month of: May 2012</th>
<th>Month of: Jun 2012</th>
<th>Month of: Jul 2012</th>
<th>Month of: Aug 2012</th>
<th>4 Month Avg</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls Offered</td>
<td>1,242</td>
<td>1,462</td>
<td>1,133</td>
<td>1,175</td>
<td>1,253</td>
<td></td>
</tr>
<tr>
<td>Calls Answered</td>
<td>1,136</td>
<td>1,041</td>
<td>1,076</td>
<td>1,147</td>
<td>1,147</td>
<td></td>
</tr>
<tr>
<td>Average Answer Delay</td>
<td>00m 25s</td>
<td>00m 31s</td>
<td>00m 34s</td>
<td>00m 34s</td>
<td>00m 31s</td>
<td>&lt;30s</td>
</tr>
<tr>
<td>Abandoned Calls</td>
<td>60</td>
<td>75</td>
<td>85</td>
<td>79</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Abandoned Calls over 30 sec</td>
<td>22</td>
<td>25</td>
<td>33</td>
<td>28</td>
<td>28</td>
<td>&gt;96%</td>
</tr>
<tr>
<td>% Service Level</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Abandonment Rate over 30 sec</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>&lt;4%</td>
</tr>
<tr>
<td>Live Connects</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Pre-Registration Measurements

How many and what percentage of preregistrations were:

- Completed?
- Not required?
- Incomplete?

How many days out are the preregistrations?

Are the goals being met?
Pre-Registration

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>8/10/2012</th>
<th>8/17/2012</th>
<th>8/24/2012</th>
<th>8/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete</td>
<td>66</td>
<td>55</td>
<td>87</td>
<td>61</td>
</tr>
<tr>
<td>Not Required</td>
<td>285</td>
<td>252</td>
<td>287</td>
<td>350</td>
</tr>
<tr>
<td>Total Complete / Not Required</td>
<td>351</td>
<td>307</td>
<td>374</td>
<td>411</td>
</tr>
<tr>
<td>Attempted - Pending External</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Incomplete</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Days Out Results</th>
<th>8/10/2012</th>
<th>8/17/2012</th>
<th>8/24/2012</th>
<th>8/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 3 Days</td>
<td>62 / 63</td>
<td>102 / 104</td>
<td>110 / 111</td>
<td>1 / 1</td>
</tr>
<tr>
<td>4 Days</td>
<td>58 / 58</td>
<td>69 / 70</td>
<td>77 / 77</td>
<td>91 / 91</td>
</tr>
<tr>
<td>5 Days</td>
<td>68 / 69</td>
<td>72 / 74</td>
<td>93 / 94</td>
<td>99 / 99</td>
</tr>
<tr>
<td>6+ Days</td>
<td>165 / 340</td>
<td>178 / 358</td>
<td>164 / 316</td>
<td>179 / 352</td>
</tr>
</tbody>
</table>
Insurance Verification Measurements

What is the volume and type of service?
- Elective inpatient
- Elective outpatient
- Urgent
- Add on

What is the percentage and volume secured at service?

Why was it not secured at service?
- Pending payor
- Pending physician

How many days out are verifications secured?

Is the goal being met?
Insurance Verification

<table>
<thead>
<tr>
<th>Elective Accounts</th>
<th>8/10/2012</th>
<th>8/17/2012</th>
<th>8/24/2012</th>
<th>8/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Inpatient Admissions</td>
<td>85</td>
<td>70</td>
<td>91</td>
<td>80</td>
</tr>
<tr>
<td>Elective Outpatient Registrations</td>
<td>685</td>
<td>749</td>
<td>678</td>
<td>749</td>
</tr>
<tr>
<td>Add On Admissions/Registrations</td>
<td>316</td>
<td>276</td>
<td>281</td>
<td>311</td>
</tr>
<tr>
<td>Total Elective Services</td>
<td>1,086</td>
<td>1,095</td>
<td>1,050</td>
<td>1,140</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Accounts</th>
<th>8/10/2012</th>
<th>8/17/2012</th>
<th>8/24/2012</th>
<th>8/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Admissions</td>
<td>748</td>
<td>772</td>
<td>778</td>
<td>759</td>
</tr>
<tr>
<td>Outpatient Registrations</td>
<td>248</td>
<td>280</td>
<td>291</td>
<td>317</td>
</tr>
<tr>
<td>Total Urgent Services</td>
<td>996</td>
<td>1,052</td>
<td>1,069</td>
<td>1,076</td>
</tr>
<tr>
<td>Total IV Services</td>
<td>2,082</td>
<td>2,147</td>
<td>2,119</td>
<td>2,216</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elective Outcomes</th>
<th>8/10/2012</th>
<th>8/17/2012</th>
<th>8/24/2012</th>
<th>8/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled Secure at Service</td>
<td>753</td>
<td>98 %</td>
<td>793</td>
<td>97 %</td>
</tr>
<tr>
<td>Add On Secure at Service</td>
<td>224</td>
<td>71 %</td>
<td>195</td>
<td>71 %</td>
</tr>
<tr>
<td>Total Secure at Service</td>
<td>977</td>
<td>90 %</td>
<td>988</td>
<td>90 %</td>
</tr>
<tr>
<td>Pending Payer</td>
<td>2</td>
<td>0 %</td>
<td>6</td>
<td>1 %</td>
</tr>
<tr>
<td>Pending Physician</td>
<td>13</td>
<td>1 %</td>
<td>8</td>
<td>1 %</td>
</tr>
<tr>
<td>Elective Incomplete</td>
<td>94</td>
<td>9 %</td>
<td>93</td>
<td>8 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DDC Days Out Results</th>
<th>8/10/2012</th>
<th>8/17/2012</th>
<th>8/24/2012</th>
<th>8/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 3 Days</td>
<td>236/238</td>
<td>99 %</td>
<td>235/237</td>
<td>99 %</td>
</tr>
<tr>
<td>4 Days</td>
<td>168/175</td>
<td>96 %</td>
<td>157/159</td>
<td>99 %</td>
</tr>
<tr>
<td>5 Days</td>
<td>177/181</td>
<td>98 %</td>
<td>124/128</td>
<td>97 %</td>
</tr>
<tr>
<td>6+ Days</td>
<td>526/635</td>
<td>83 %</td>
<td>573/651</td>
<td>88 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Outcomes</th>
<th>8/10/2012</th>
<th>8/17/2012</th>
<th>8/24/2012</th>
<th>8/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Due Diligence Complete</td>
<td>927</td>
<td>93 %</td>
<td>1,029</td>
<td>98 %</td>
</tr>
<tr>
<td>Urgent Incomplete</td>
<td>60</td>
<td>7 %</td>
<td>23</td>
<td>2 %</td>
</tr>
</tbody>
</table>
How many patients were screened in-house?

How many were attempted and not completed?

Why were they not completed?
- Language Barrier
- Patient Receiving Treatment
- Incapacitated
- Uncooperative

How many were not completed in-house?
- Short Stay
- Weekend

How does this compare to goal?
## Financial Counseling

### In House Screening Summary

<table>
<thead>
<tr>
<th></th>
<th>8/10/2012</th>
<th>8/17/2012</th>
<th>8/24/2012</th>
<th>8/31/2012</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total - Completed In House</td>
<td>71</td>
<td>60</td>
<td>67</td>
<td>71</td>
<td>95 %</td>
</tr>
<tr>
<td>Total - Attempted Not Completed</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1 %</td>
</tr>
<tr>
<td>Language Barrier</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 %</td>
</tr>
<tr>
<td>Patient Receiving Treatment</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1 %</td>
</tr>
<tr>
<td>Patient Incapacitated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 %</td>
</tr>
<tr>
<td>Patient Uncooperative</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 %</td>
</tr>
<tr>
<td>Attempted Other</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0 %</td>
</tr>
<tr>
<td>Total - Not Attempted In House</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>8 %</td>
</tr>
<tr>
<td>Short Stay</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2 %</td>
</tr>
<tr>
<td>Weekend Discharges</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3 %</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1 %</td>
</tr>
</tbody>
</table>

### Screening Completed In House Percent

- 06/08/2012: 100%
- 06/15/2012: 100%
- 06/29/2012: 100%
- 07/06/2012: 100%
- 07/13/2012: 100%
- 07/27/2012: 100%
- 08/03/2012: 100%
- 08/10/2012: 100%
- 08/24/2012: 100%
Point of Service Measurements

What locations are cash being collected?

How much is being collected?

How does the cash compare to goal?

How does it compare to the prior month?

Based on the cash for the month to date, how is it pacing to goal?

Who are the top collectors?
## Point of Service

<table>
<thead>
<tr>
<th>Access Point</th>
<th>MTD Prior Rcps</th>
<th>MTD Current Rcps</th>
<th>MTD Rcps</th>
<th>Goal</th>
<th>% to Goal</th>
<th>Pacing</th>
<th>Pacing to Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY</td>
<td>$6,781</td>
<td>$19,075</td>
<td>$25,856</td>
<td>$30,858</td>
<td>83.8%</td>
<td>$29,833</td>
<td>96.7%</td>
</tr>
<tr>
<td>FC/CASHIER</td>
<td>$4,141</td>
<td>$0</td>
<td>$4,141</td>
<td>$7,949</td>
<td>52.1%</td>
<td>$4,778</td>
<td>60.1%</td>
</tr>
<tr>
<td>OUTPATIENT</td>
<td>$2,412</td>
<td>$8,985</td>
<td>$11,397</td>
<td>$7,608</td>
<td>149.8%</td>
<td>$13,150</td>
<td>172.9%</td>
</tr>
<tr>
<td>PATIENT ACCESS</td>
<td>$171</td>
<td>$553</td>
<td>$724</td>
<td>$1,307</td>
<td>55.4%</td>
<td>$835</td>
<td>63.9%</td>
</tr>
<tr>
<td>SURGERY</td>
<td>$4</td>
<td>$8,269</td>
<td>$8,273</td>
<td>$5,915</td>
<td>139.9%</td>
<td>$9,545</td>
<td>161.4%</td>
</tr>
<tr>
<td>UNASSIGNED/OTHER</td>
<td>$331</td>
<td>$3,775</td>
<td>$4,106</td>
<td>$3,182</td>
<td>129.1%</td>
<td>$4,738</td>
<td>148.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$13,839</strong></td>
<td><strong>$40,657</strong></td>
<td><strong>$54,496</strong></td>
<td><strong>$56,818</strong></td>
<td><strong>95.9%</strong></td>
<td><strong>$62,880</strong></td>
<td><strong>110.7%</strong></td>
</tr>
</tbody>
</table>
PFS Measurements

Account follow-up based on dollar stratification

Summarization of accounts that are not followed up timely

Weekly staff Quality Review Scores

Weekly reporting of accounts needing review by Patient Accounts, Patient Access, Clinical Departments or HIM

Reports identify how collector followed up on accounts
TRAC(R) Summary

Provena Health
Facility: ALL - All

Key A/R Statistics

<table>
<thead>
<tr>
<th>Gross</th>
<th>Days</th>
<th>Change</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incl. Unposted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing WIP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-Up WIP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Daily Averages

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Current</th>
<th>13-week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posted Cash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posted Cash/13ADR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posted Cash/Relief</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Weekly Posted Cash and Adjustments

Weekly Adjusted Weekly Posted Cash

<table>
<thead>
<tr>
<th>06/22/2012</th>
<th>06/29/2012</th>
<th>07/06/2012</th>
<th>07/13/2012</th>
<th>07/20/2012</th>
<th>07/27/2012</th>
<th>08/03/2012</th>
<th>08/10/2012</th>
<th>08/17/2012</th>
<th>08/24/2012</th>
<th>09/07/2012</th>
<th>09/14/2012</th>
</tr>
</thead>
</table>

Billing WIP

<table>
<thead>
<tr>
<th>Patient Access</th>
<th>Current</th>
<th>Change</th>
<th>Goal</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Info, Mgmt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Departments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pt. Financial Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Follow-Up WIP

<table>
<thead>
<tr>
<th>$10K+</th>
<th>Number</th>
<th>Balance</th>
<th>#Change</th>
<th>$Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1K - $10K</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0 - $1K</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments
### QUIC(TM) Weekly Billing WIP Summary Facility Breakout

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>CURRENT</th>
<th></th>
<th>CHANGE</th>
<th></th>
<th>4 WEEK AVERAGE</th>
<th></th>
<th>DELINQUENT</th>
<th></th>
<th>INFLOW</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Dollar</td>
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Monthly Denials Avoidance

- Why tracking denials is important
- Monthly revenue cycle ("accountability") meeting
- RCA analyzed and provides a "deeper dive" to ensure accountability
- What happens in between meetings – Root Cause Analysis (RCA) discipline
Monthly Denials Avoidance

DENIALS - RCA TRACKING REPORT
For the weeks ended April 14 - August 04, 2012

Number of Denial Accounts - RCA Completed

Percent Completed: 95.4% 93.7% 77.6% 79.9% 83.2% 85.7% 71.6% 62.6% 86.4% 77.0% 72.8% 79.1% 77.8%

TOTAL
**Root Cause Analysis Form**

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### Describe Process Breakdown ("Root Cause")

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<th>Who is Accountable?</th>
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### Questions

- Was the denial(s) the result of a training issue? [ ] Yes [ ] No
- Does a procedure or checklist need to be created / revised? [ ] Yes [ ] No
- Were denials the result of a bad hand-off between 2 departments? [ ] Yes [ ] No
- Would a claim edit identify this error prior to billing? [ ] Yes [ ] No
- Does Managed Care need to be involved to solve issue? [ ] Yes [ ] No

What training, procedural, hand-off, or managed care improvement can be refined to prevent this denial from recurring?

1. 
2. 
3. 

**Avoidability Score:**

- [ ] Completely Avoidable
- [ ] Often Avoidable
- [ ] 1-25% Avoidable
- [ ] Unavoidable

**"Table" Signature:**

**Date Reviewed:** 02/09/2012
## Monthly Denials Avoidance

### RCA Categories

- Patient Access
- Utilization Review
- Medical Records
- Clinical Departments
- Managed Care Contracting
- Patient Financial Services
- PFS – MISC
- RAC

### Medical Records

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Monthly KPI

- Cash Collections - (By payor and Location)
- Bad Debt - (Before and After Insurance)
- Charity – (AR and BD)
- Denials - (By Area of Responsibility)
- Accounts Receivable (AR)
- Billed AR Breakdown – (By payor)
- > 90 Day Breakdown – (By payor)
- Credit Balances
- Overall Days in A/R
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</table>
**Monthly KPI**

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<tr>
<th></th>
<th>March-12</th>
<th>April-12</th>
<th>May-12</th>
<th>June-12</th>
<th>July-12</th>
<th>August-12</th>
<th>CY12 AVG</th>
<th>CY12 Total</th>
<th>CY11 AVG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Revenue</td>
<td>814,578,395</td>
<td>794,084,372</td>
<td>790,672,311</td>
<td>786,327,250</td>
<td>793,063,648</td>
<td>782,596,740</td>
<td>782,990,740</td>
<td>782,990,740</td>
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<tr>
<td>Net Revenue</td>
<td>1,711,936,727</td>
<td>1,702,132,377</td>
<td>1,717,454,295</td>
<td>1,683,231,364</td>
<td>1,693,539,465</td>
<td>1,673,970,239</td>
<td>1,673,970,239</td>
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<td>1,673,970,239</td>
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<tr>
<td>Net Revenue Per Day</td>
<td>5,509,991</td>
<td>5,545,653</td>
<td>5,545,599</td>
<td>5,545,459</td>
<td>5,622,685</td>
<td>5,528,273</td>
<td>5,673,000</td>
<td>5,673,000</td>
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</tbody>
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**Accounts Receivable:**
- Inhouse
- DNFB
- Billed
- Vendor/Client
- Total

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<td>$ over 90 days</td>
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<td>% over 90 days</td>
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<td>$ over 365 days</td>
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<td>% over 365 days</td>
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</tbody>
</table>

**Billed AR Breakdown:**
- Medicare
- Public Aid
- CCMC
- Govt Misc
- Self Pay
- Total MANG
- MANG RHC
- R&B MANG
- Medassist
- Vendor/Client

**Credit Balances:**
- # of Accounts
- $ of Accounts
- Total Billed AR Breakdown

---

**Presence Health™**
### Monthly KPI

#### Over 90 Days Breakdown:
- Medicare
- Public Aid
- CCMC
- Govt Misc
- Self Pay
- Total MANG
  - MANG RHC
  - R&B MANG
  - Medassist
  - Vendor/Client

#### Credit Balances:
- # of Accounts
- $ of Accounts
- Total 90 Days Breakdown

#### A/R Days (excludes cushion):
- Gross
- Net

---

[Presence Health Logo]
Summing it up?

Measurement leads to Quality

Measurement identifies training needs

It is not enough to measure monthly needs