

# Revenue Cycle

## Functionality Brief



MEDITECH's Revenue Cycle solution automates billing claim tracking across multiple facilities to assist with every aspect of your healthcare organization's billing and collection efforts. Support for both centralized and decentralized billing, along with conflict checking, denial management, and integrated charge capture, all help to reduce AR days and ensure optimal reimbursement.

### *Highlights:*

- Quickly access all patient account and billing details from a single desktop
- Automate charge capture from integrated MEDITECH applications
- Calculate actual versus expected reimbursements via contract management
- Proactively prevent claim denials through conflict checking
- Utilize multiple claim formats (UB04, 1500, 837 I/P)
- Electronically submit claims and receive remittances via ANSI 837/835
- Manage and prioritize the collection of unpaid claims to reduce AR Days
- Quickly follow up on denials to reduce lost dollars

### *Revenue Cycle Enables Billing Staff to:*

#### **Manage All Processes from Centralized Desktops**

The Revenue Cycle solution provides your staff with centralized access to all of the routines necessary to perform their job functions through customizable roles-based desktops. The foundation of the Revenue Cycle solution is the Process Account routine, which allows users to view detailed billing information for all account types and statuses, as well as data captured in other integrated MEDITECH applications, including:

- Demographic and insurance data, with changes updating selected accounts
- Diagnosis, procedure, DRG, and PPS codes from Abstracting
- Charges, organized by revenue code, detail, department, procedure, or bill
- The status and balance of claims for multiple form types (UB04, 1500)
- Collection information, such as patient statements, reminders, and letters
- Scanned documents, such as insurance cards or healthcare proxies.

Access to this information is invaluable when handling patient inquiries, preparing claims for submission, engaging in collection efforts, and processing denials.

#### **Establish Consistent Charge Rates across your System**

Revenue Cycle supports automated charge capture through integration with appropriate MEDITECH applications, which drastically reduces instances of late and lost charges. The charge master contains current, historic, and future effective dates, along with respective charge amounts for all items and procedures. Whenever mass updates are made to the charge master, the system automatically applies new charge amounts based on effective dates. Procedure names can also be spelled out to support patient-friendly statement generation. Revenue and statistical information is tracked back to the General Ledger, while CPT and HCPCS codes can be automatically applied when mapping charges to claim forms.

## Determine Expected Reimbursement with Contract Management

Contract management functionality within Revenue Cycle allows your organization to easily enter contract terms in the system to determine expected reimbursements. Staff can incorporate such reimbursement methods as: procedure codes; revenue codes; DRG, ICD, or PPS codes; and account type, and can choose to take adjustments at the time of billing or remittance. Revenue Cycle also features standard contract reports to help you evaluate expected versus actual reimbursements.

## Reduce the Likelihood of Denied Claims through Conflict Checking

The Revenue Cycle solution provides conflict checks to ensure claims contain all necessary information prior to submission. Rejections are sent to a Biller Desktop, where your staff can manage and resolve all assigned issues. Worklist capabilities allow staff to filter assigned accounts to prioritize workload, as well as graphically view rejected dollar amounts and performance metrics to monitor productivity. There are three different points in the billing process when accounts pass through claim checks to reduce instances of denials:

- Pre-bill checks, which allow your staff to proactively flag unbilled accounts
- Bill cycle checks, which occur during the proration process
- Claim checks, applied to specific claim formats to reflect payer specifications.

Accounts pass through such checks prior to claim submissions made either directly to payers, or through a clearinghouse. If your organization uses a third-party claims scrubber, then MEDITECH can also provide you with a standard interface for submitting claims to that clearinghouse.

## Generate Multiple Bill Types and Claim Forms, and Track Remittances

MEDITECH's Revenue Cycle solution provides your organization the ability to automatically generate an unlimited number of bills (final, interim, date range, late) based on facility-defined billing cycles by insurance and account types. Supported claim formats include the UB04, 1500, and 837 I/P, with each claim containing a unique reference number to ensure accurate posting of payments, adjustments, and denials to both the account and claim level. Other features of Revenue Cycle include the ability to:

- Collect and record patient co-pays prior to discharge, and provide receipts
- Provide patient-friendly bills, with clear descriptions of all charges
- Submit claims to insurance companies electronically
- Electronically post 835 batches to the appropriate claim
- Perform secondary billing based on receipts/elapsed days without activity
- Post adjustments and refunds to the appropriate General Ledger account
- Establish proration rules for late charge bills
- Generate cycle statements, including patient messages and automatic interest posting.

## Follow up on Collections to Minimize AR Days

A Collector Desktop enables staff to follow up on outstanding balances for those specific insurances or account types assigned to them. The Desktop provides a graphical aged trial balance view of assigned accounts, as well as a reminder queue of accounts needing specific attention. Your organization can define which accounts are flagged for collection based on non-receipt of payment, high balances, as well as facility-defined criteria. Collectors then have the ability to prioritize follow-up efforts based on dollar balances, AR age, or reminder due dates to keep AR days low. When managing collections, your staff has the ability to:

- Display patient/guarantor demographics and account statuses, patient and insurance balances, transaction details, and follow-up statement histories
- Process manual or automated reminders, including timeframes for follow up
- Enter free text and coded comments and view account notes and reminders
- Generate letters and incorporate pre-defined messages based on days outstanding
- View all insurance balances for a single patient to support collection inquiries.

Your organization can also define criteria for submitting accounts to a collection agency via a standard interface,

for example, over 120 days outstanding and three letters sent. Staff can also compile and transfer accounts to bad debt status per organization-defined criteria.

### Track, Analyze, and Prevent Denials

A Denial Management Desktop provides your staff with a tool to analyze and track current sources of denials, in order to prevent them in the future. Denial information is automatically routed to the worklist when receiving electronic remits from payers via ANSI 835 or when posting remit batches. Your organization has the flexibility to determine user follow-up responsibility, and staff can then manage the appeals process by:

- Tracking and updating the current status of denials and documenting notes
- Reviewing pertinent information for denial reason to follow up appropriately
- Documenting payments received as “Recovered Amounts.”

The Denial Management feature also includes a number of standard reports to view top sources of denials by payer, account type, and hospital department, as well as productivity reports to track user workload, appeals, and dollars recovered. These reports help detect trends, improve processes, and ultimately prevent future denials.

### Oversee Performance through Comprehensive Reporting

Your organization can better manage your revenue cycle processes and evaluate performance through a comprehensive set of standard and customer-defined reports. Standard reports delivered with MEDITECH’s Revenue Cycle solution include:

- Operations Summary: all Revenue Cycle activity for a period, date, or range of dates
- Receivable reports: UR summary, Bad Debt summary, and AR summaries by insurance, account type, and collector
- Revenue reports: period comparisons by breakdown and pricing, patient, and procedure revenues
- Aged trial balances: period, insurance, account breakdowns
- Denial management: top denial sources by payer, department, and user productivity.

### Reap the Benefits of Integration

System-wide integration improves reimbursement by minimizing lost charges, reducing claim rejections due to missing information, and lowering AR days. Benefits include:

- Automatic receipt of charges from other MEDITECH applications
- Receipt of diagnosis and procedure codes from Abstracting
- Bi-directional updates of demographic and insurance data via Registration
- Submission of billing and patient refund data to the General Ledger
- The ability to scan and index billing documents via Scanning and Archiving
- Submission of patient and insurance refund information to Accounts Payable
- Access to view, edit, and create referrals via Authorization and Referral Management.

For more information about us, contact a MEDITECH Marketing Consultant.

April 06, 2010