Revenue Cycle Overview

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On a National front…

- Non-Federal payers 'negotitate' contracted rates with Hospitals, Health Systems and Professional/Physician Groups
- Software and administrative structures monitor that insurance companies pay agreed upon rates and for federal programs the rates currently published for the services provided

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In Maryland…

- Professional/Physician groups parallel the National process
- Hospitals are paid based on an "all-payer" system regulated by the Health Services Cost Review Commission (HSCRC)

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Johns Hopkins Medicine
Clinical Revenue Management Structure

Johns Hopkins University
Clinical Practice Association

Physicians Billing Service
(Billing and Collections for Professional fee providers)

Johns Hopkins Health System
Patient Financial Services

- **The Johns Hopkins Hospital**
- **Johns Hopkins Bayview Medical Center**
- **Howard County General Hospital**

Additional Billing Groups

- **Community Physicians**
- **Johns Hopkins Home Care Group**

- **Working towards a single patient identifier for Johns Hopkins Medicine**
- **Shared demographic and insurance data**
- **Collaboration on issues resolution**
- **Shared insurance/payer contracting**
- **Aligned approach for Patient Management Systems**
- **Key Business Metrics**

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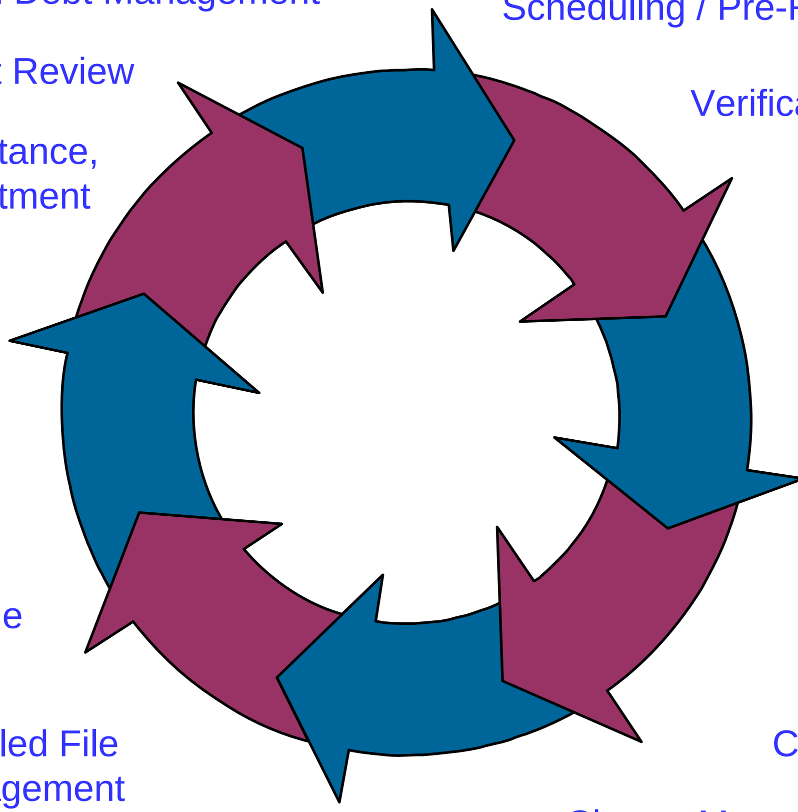
Components of the Revenue Cycle



Scheduling / Pre-Registration/Registration

Verification/Authorization

Point of Service Collections

Medical Record / Encounter Form Created

Utilization Management

Patient Care Rendered/Documented

Concurrent Review

Charge Capture

Charge Master

Encounter/Chart Coded

Unbilled File Management

Late Charge Control

Billing Process

Follow-up

Denial/Appeals Management

Electronic Remittance, Cash and Adjustment Process

Reimbursement Review

Bad Debt Management

Management Reporting/Key Indicators

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History of Initiative

- Revenue cycle focus for JHM began in late Fiscal Year 1998
- Areas targeted for improvement were The Johns Hopkins Hospital and the School of Medicine
  - Access Services (Scheduling, Registration and Insurance Verification)
  - Administrative Denials

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Goals of Revenue Cycle Process

- Improve patient service with an accounts management approach
- Administrative processes completed prior to the date of service
- Streamline workflow design and increase automation
- Improve internal and external customer relations
- Increase cash flow by improving Time of Service Collections
- Improve accuracy of registration data and competency of staff
- Increase appeal and recovery rates
- Reduce denial rates
- Increase number of inpatient days re-certified
- Ensure compliance with regulatory requirements

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Monitoring & Metrics

- Developed baseline data for each area of focus and targets
- Whenever possible, used industry benchmarks and "best practice"
- Routinely produce key indicators / report cards

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Rejection Analysis

- Review existing rejection reporting and feedback process
- Establish rejection ownership
  - Registration
  - Coding/Medical Records
- Assess areas of weakness/risk
  - Primary payer identification
  - Authorizations
  - Lack of Eligibility
- Focus on high volume payers and rejection sites

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Collection Rate Evaluation

- Review collection rate by inpatient service and source of admission (emergency, urgent, elective)
- Assess outpatient collection rate by registration site
- Evaluate inpatient and outpatient collection rate by payer

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Revenue Capture- Process Review

- Late Charge review / collection rate impact
- Charge error correction process
- Ancillary system revenue controls and reporting
- Registrations without charges
- Accountability for revenue control process in each service area
- Policy / procedures compliance and audit

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Key Indicators

- Competency Scoring
- Collection rate/net collection rate by service registration site and payer
- Days outstanding in Accounts Receivable
- Aging of outstanding receivables
- Point of Service cash collections
- Unbilled Receivables by Reason
- Monthly cash collections
- Denied clinical and administrative days and value
- Late Charges
- Rejection percent by payer/location

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Mechanics of Claim Production Overview

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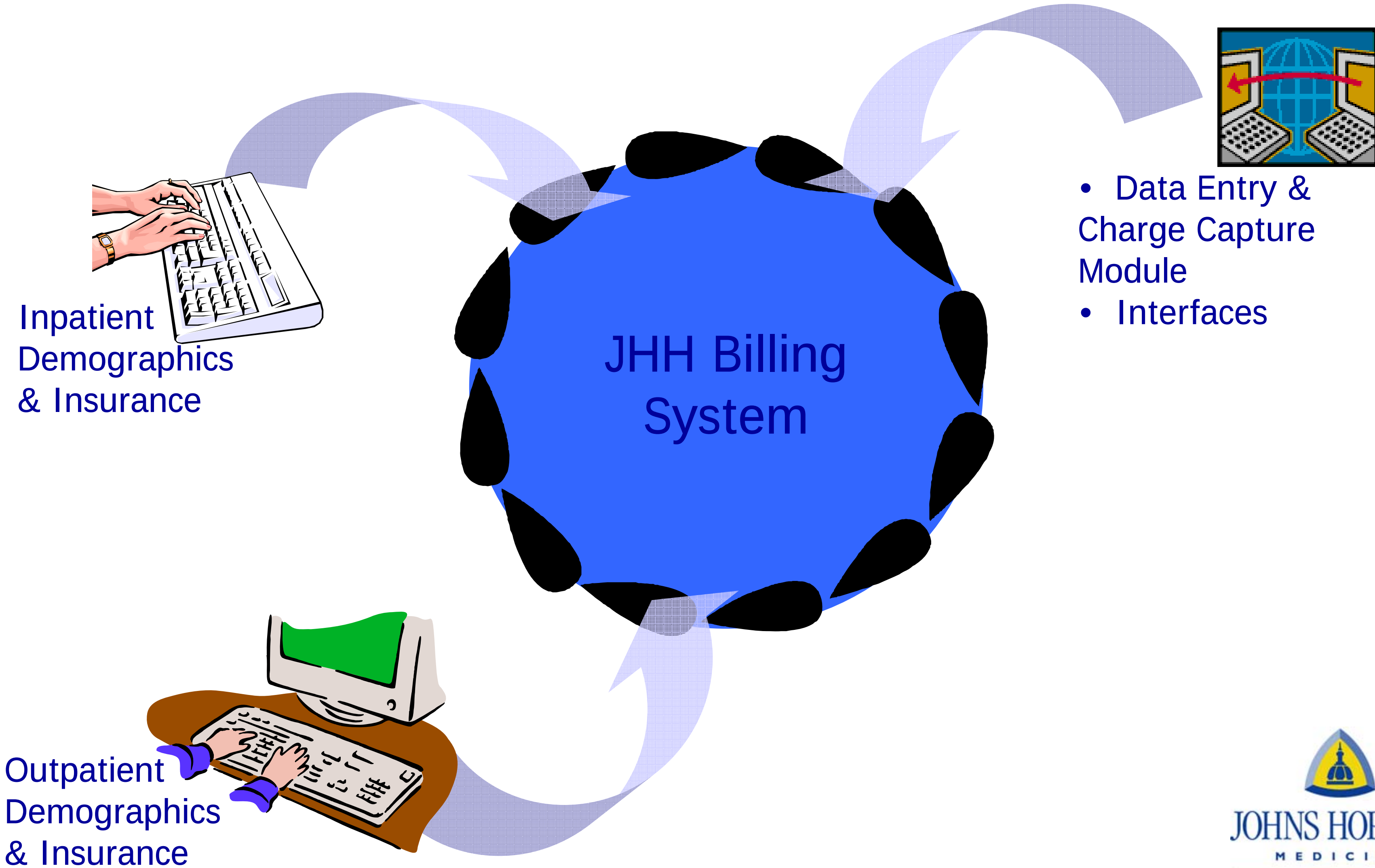
The Johns Hopkins Hospital



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Interfaced Charges

- Anesthesia
- Operating Room
- Rehabilitative Medicine Services
- Cardiovascular Diagnostic Lab
- EKG
- Supplies

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Interfaced Charges (cont'd)

- Respiratory Medicine
- Radiology
- Oncology
- Pharmacy
- Laboratory
- Ophthalmology Procedures

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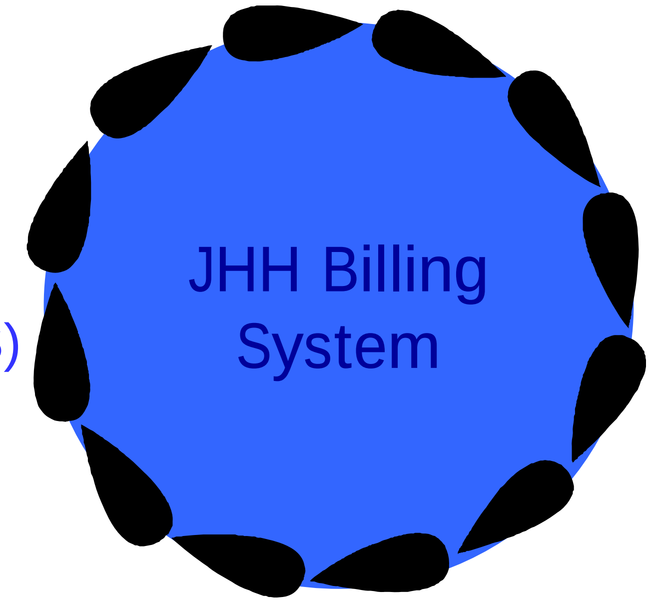
Key Files



- Charge Description Master
  - Assigns Procedural Codes (CPT/HCPCS)
  - Assigns Uniform Bill Revenue Codes
  - Pricing
  - HSCRC- Relative Value Units
  - General Ledger Revenue Centers
  - Cost Standards for Decision Support
- Room & Board
  - Assigns Room Rate, coding based on patient location and room type
- Provider Files
  - Assigns National Provider Identifier (NPI)
- Insurance File
  - Payers
- Locations
- Patient Types
- Medical Service

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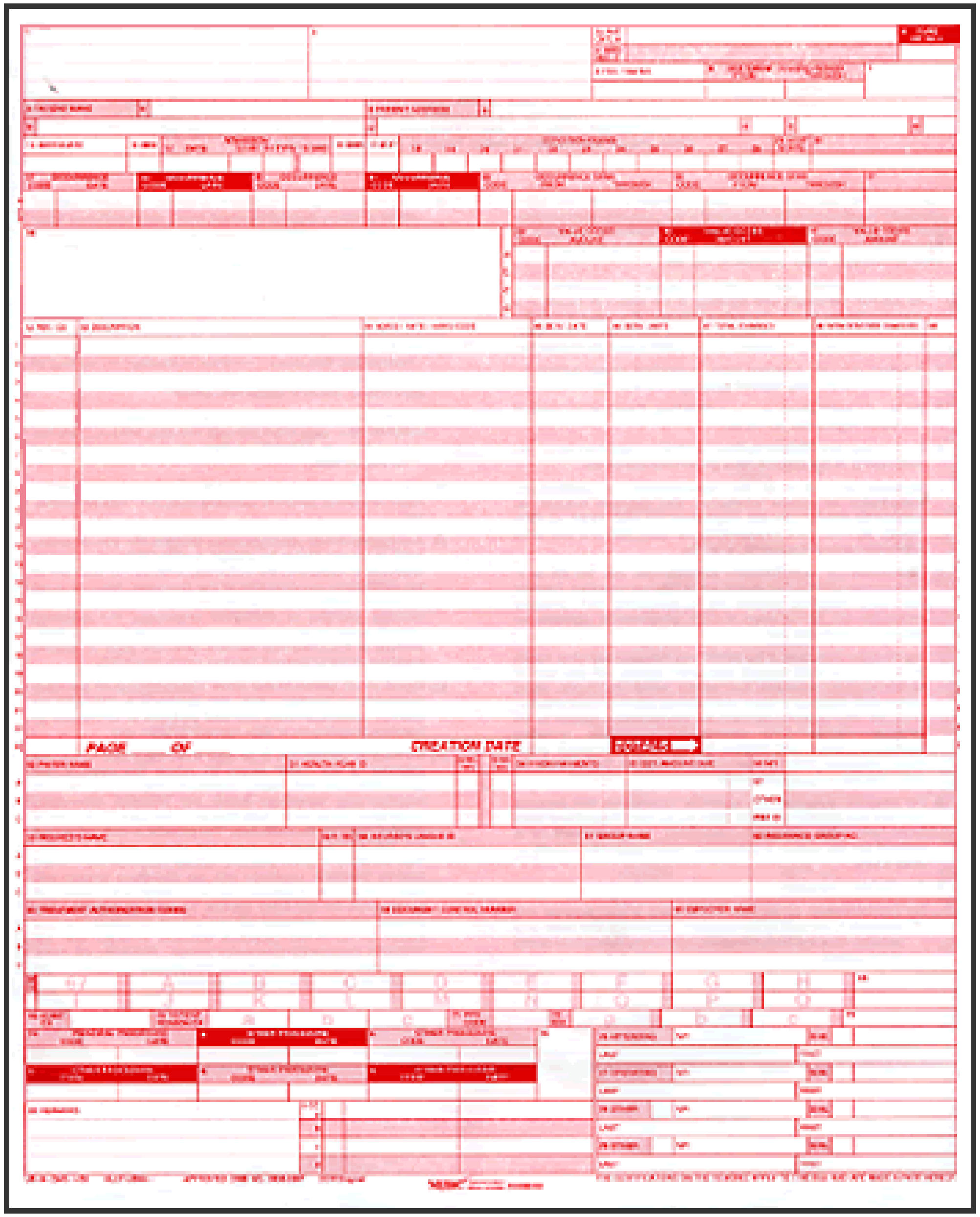
Hospital Claim Form



UB04

(Uniform Bill- 2004 version) for hospital/institutional claims

-National standard

-Electronic Billing equivalent is a standardized transaction set (837I)

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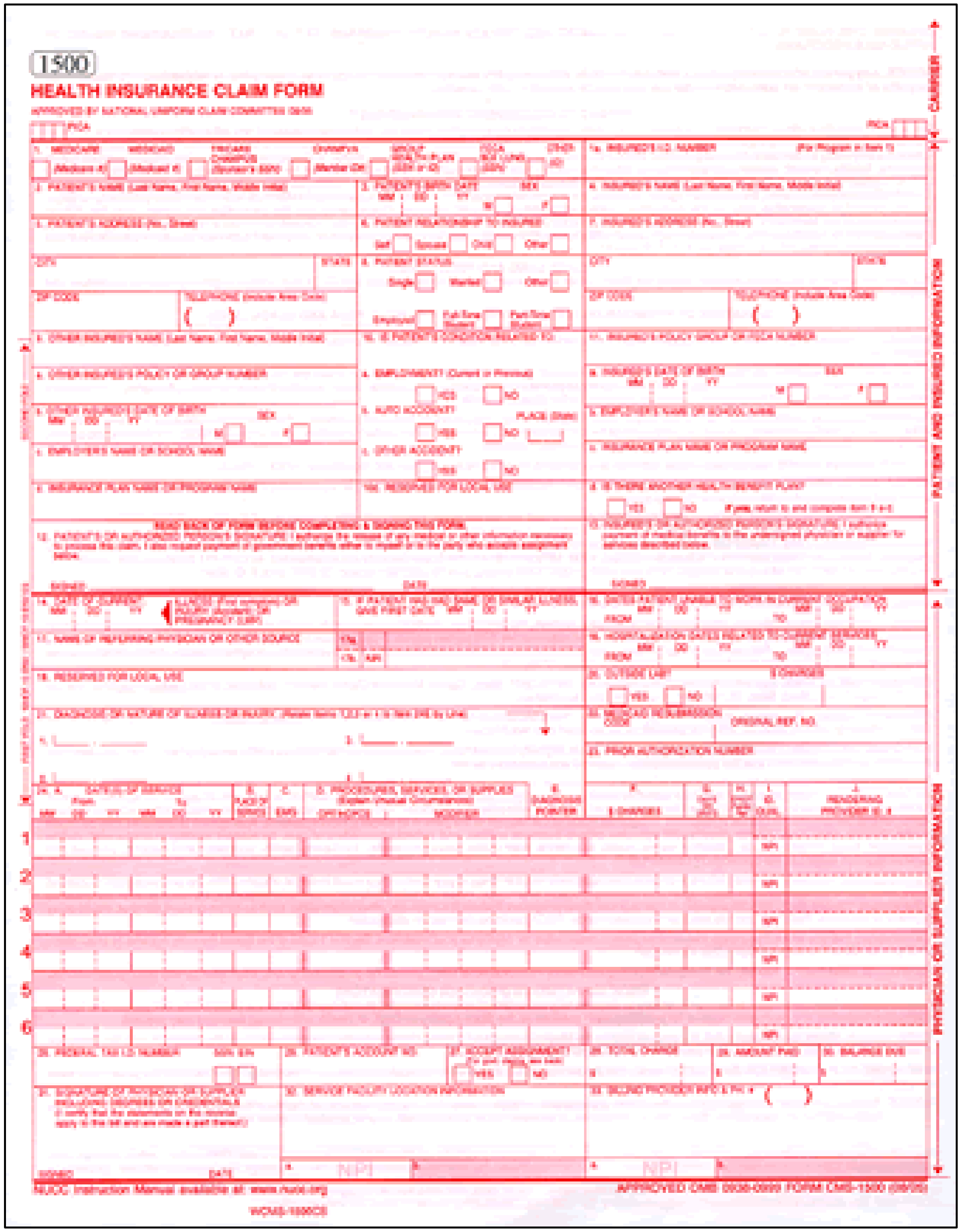
Professional Fee Claim Form


1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1500

(For professional fee claims and unregulated claims)

- National Standard

- Electronic Billing equivalent is a standardized transaction set (837P)

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Questions?

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