Revenue Cycle Management (RCM) Best Practices

Recommended that this tool is used in conjunction with the Denial Tool and Billing Tool

Looking for something specific? Use control/command F and type in the word.

Denial Codes listed are from the **national code set**. For more information on remark codes **view here.**

Stage	*Element*	*Best Practices for this Element*	*Relevant Billing Tool Fields and/or Potential Denial Codes if Completed Incorrectly*
Prior to Service	Eligibility Verification	• When possible insurance eligibility and benefit verification should take place before the initial visit and checked regularly after that. • Staff should have a working knowledge of the most commonly seen insurance plans and coverage options.	Potential Denial Codes: 31, 24
Prior to Service	Authorization	• Identify what authorizations, if any, are required for the service. • Know each payer's process for securing authorizations as well as authorization timeframes. • Have a procedure to track any authorization limits. • If authorization is not required, be sure to abide by any MMCP notification requirements.	Field 63 Potential Denial Codes: 197, 62
Prior to Service	Scheduling	• When possible, scheduling should be centralized and electronic. • If an insurance plan requires staff to have specific credentials to deliver a reimbursable service, care should be taken to ensure the client is scheduled with an approved provider in order to be reimbursed for the service.	Potential Denial Codes: 185, B7

Stage	***Element***	***Best Practices for this Element***	***Relevant Billing Tool Fields and/or Potential Denial Codes if Completed Incorrectly***
During Service	New Client Registration	• Efficiently collect information necessary to establish a new client record including basic demographics, financial information, and financial agreements. • Clients also need to be made aware of fee policies and payment responsibility, if any, that the client/family may have.	Field 8,9,10,11, 60. Potential Denial Code: 16

During Service	Eligibility Verification	• Medicaid Fee for service and Medicaid Managed Care verifications can be done by:
		  ○ Telephone
		  ○ VeriFone Vx570
		  ○ ePACES
		  ○ Batch upload (270)
		  ○ Plan online portals
		• The most efficient means to verify Medicaid eligibility is the electronic transmission of a 270 directly from the billing component of your EMR/EHR or billing software.
		• Many Medicaid Managed Care Plans encourage providers to verify member Eligibility and Benefits on their Provider Portals prior to rendering services.
			Potential Denial Codes: 31, 24

During Service	Charge Capture and Coding	• Whenever possible charge capture should be standardized. One of the approaches is to develop and implement a Chargemaster. • An efficient process must be in place to record, verify, and accurately report services provided and enter them into the billing program. • Strong quality assurance programs must be in place to assure codes and modifiers are correct and supported by the clinical documentation.	Field 39, 42, 43 (if plan requires), 44, 45, 46, 47 Potential Denial Codes: 4, 11, 16, 18, 199

Stage	***Element***	***Best Practices for this Element***	***Relevant Billing Tool Fields and/or Potential Denial Codes if Completed Incorrectly***
		• Staff should understand the billing rules that guide their practice and documentation.	
After Services	Claim Submission	• Submit billable fees to the plan via the required universal claim form. • Claim data can be submitted directly to the payer or through a clearinghouse. • Processes must be in place to "scrub" claims to assure that they are clean. • Claims should be submitted as soon as feasible and well within timely filing deadlines.	Field 39, 42, 44, 45, 46, 47 In addition to those fields, utilize the Billing Tool to determine which fields are required by which plan. Potential Denial Code: 29

After Services	Claim Submission	• Processes must be in place to "scrub" claims to assure that they are clean.
		• Some common tests:
		  ○ Was the claim formatted correctly and are all required data elements present
		  ○ Was the service of the required duration for the code inputted
		  ○ Was only one rate code billed on the claim
		  ○ Did the rate code and procedure code/ modifier combinations align with State billing manuals
		  ○ Was the documentation completed properly:
		  ■ Progress note was completed
		  ■ Service was on the treatment plan
		  ■ Treatment plan was up to date.
			Field 42, 44, 45, 46, 47
			
			In addition to those fields, utilize the Billing Tool to determine which fields are required by which plan.
			
			Potential Denial Codes: 4, 11, 16, 18, 199

After Services	Payer Follow-up	• EHR, clearinghouse or Quality Assurance Team should generate claim reports. Denial Reports: ○ Carefully review denial reports regularly.	Field 4 Utilize MCTAC Denial Tool

Stage	Element	Best Practices for this Element	Relevant Billing Tool Fields and/or Potential Denial Codes if Completed Incorrectly
		○ Communicate with Managed Care Plans (your provider relations or billing representative) if you do not understand the reason for a denial. ○ Adjudicate claims, correct errors and resubmit properly. ○ If there are trends in denial reasons, determine if there is an error in your system configuration or a way to configure your EHR or clearinghouse to safeguard against the trending denial reasons. ● Reports on unreleased claims (Not Billed or Rejected by EHR/EMR or clearinghouse): Due to configurations of EHRs or clearinghouse there may be instances in which claims are not released by the system because information is missing or incorrect. ○ Be sure to review unreleased claim reports in addition to denial reports. ○ Correct those claims so they can be properly submitted. ● Pending: Be aware of any claims that are pending and provide additional information if appropriate. ● Ensure claims are corrected before resubmitting to avoid unnecessary duplicate denials. ● Utilize proper bill types to indicate replacement claim to the original.	for top denial reasons and utilize the MCTAC Billing Tool to review claim requirements for each plan.
After Services	Remittance Process and Posting	● Post payments in a timely fashion. ● Compare payments received to payments billed and reconcile any differences. ● Review adjustments made by the payer to individual claims. Appeal adjustments when warranted.	Potential Denial Code: 29

Stage	***Element***	***Best Practices for this Element***	***Relevant Billing Tool Fields and/or Potential Denial Codes if Completed Incorrectly***
		• Contact Managed Care Plan with any remittance questions or issues.	

Ongoing	Analysis	• Review and evaluate the effectiveness of your revenue cycle management and the performance of your payers.
		  ○ Create analysis standard metrics to identify issues and processes that may need improvement.
		  ■ Some standard metrics: collection ratio, aged accounts receivable, denial report percentages, percentage of claims paid upon initial submission.
		  ○ Quantify issues related to payers and discuss with your customer service representatives.
			n/a

Ongoing	Process Improvement	• Engage in continuous quality improvement. • Have a formalized process using your analytics to identify problems, create solutions, implement change, and measure the results. • Participate in claims testing opportunities with plans.	n/a
Ongoing	Credentialing	• Ensure that your provider profile is up-to-date with the Plan. If you add or remove a service/program make sure to share all necessary information with the Medicaid Managed Care Plans you contract with. View the MCTAC Matrix for contact information for each MMCP. https://matrix.ctacny.org/	n/a