RAY JORGENSEN
CONSULTING

# Attributes of Better Performing Billing Departments

**Level:** Intermediate to Advanced

**Track:** Finance/Leadership

**Target Audience:** Senior Administrators, Financial Professionals, Board Members

**Description:** How is Revenue Cycle Management different from "billing only" shops? Are you conducting pre-claim auditing? What is your measured benchmark for providers to submit charges? How many clearinghouses do you use (did you know you probably use >1?)? Who are your Medicaid, Medicare, and other commercial payer experts… and how would you know how to identify them? Are the CFO and billing/RCM leadership team on the same page in terms of defining "successful" work product/performance? Attend this session to look beyond the billing department to better understand the roles of all revenue cycle stakeholders. Understand how to measure and improve billing staff productivity in the areas of charge capture, payment posting, and denials management. Explore critical elements of EDI reporting (pre-clearinghouse transmission and post-payer adjudication) in order to maximize their and your performance. KPIs are critical but learning what processes to modify (and how) will help your health center become the best of the breed.

**Learning Objectives:**

1. Learn what to do to improve KPI performance vs. just what KPI numbers are optimal.
2. Know how to determine your denial (vs. first pass/fail) rate and recommended steps for improvement.
3. Understand which metrics to share with different audiences and why.

**Duration:** 1–1.5 hours

**Q&A:**

1. Health center revenue cycle management (RCM) means simply sending bills to third-party payers and patients. True/False (*False*)
2. Front desk staff requires a nominal understanding of sliding fee program, health insurance benefits, available financial support programs, how to ask for money, and managing difficult patients. True/False *(True)*

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3. Charge entry lag measures the days from a DOS and the bill date. True/False *(True)*
4. Providers who "close" EMR charges weeks after DOS, negatively impact RCM performance. True/False *(True)*
5. Health centers always work with only one clearinghouse to electronically transmit payer claims. True/False (*False*)
6. Diligently working unpaid claims is necessary to maximize third-party payer payments. True/False *(True)*
7. Rejections and denials are the same thing. True/False (*False*)
8. RTP stands for Returned to Provider. True/False *(True)*
9. ERA (i.e., direct deposit) is desirable and the fastest option for third-party payer deposits. True/False *(True)*
10. A health center with 96,000 third-party payer encounters would have RCM appropriately staffed with approximately 7–9 FTEs. True/False *(True)*

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