Revenue Cycle Management

The Keys to Revenue Cycle Success: Aligning People, Process and Technology
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Agenda

- Introductions
- Define the Revenue Cycle
  - Front-End
  - Mid-Cycle
  - Back-End
- Keys to Success
  - People
  - Process
  - Technology
- Summary
Keys to a Successful Revenue Cycle
Aligning People, Process and Technology
Define Revenue Cycle

The Healthcare Financial Management Association (HFMA) defines a revenue cycle as “All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue.”
Define Revenue Cycle

- The revenue cycle includes everything from scheduling to medical care and ends with the collection of the final correct payment.
- The revenue cycle is very dynamic and changes constantly over time.
- When processes are executed correctly, the cycle performs predictably.
- Each step in the revenue cycle is a “moment of truth”.
- GOAL: accurate and complete medical record; timely and accurate billing; patient safety and patient satisfaction.
Keys to a Successful Revenue Cycle

TECHNOLOGY
- Accessibility
- Utilization
- Efficiency
- Support
- Platforms

PROCESS
- Governance
- Policies
- Workflows
- Measurements
- Communication
- Philosophy

PEOPLE
- Employee engagement
- Executive support
- Change management
- Collaboration
- Organizational structure
Keys to a Successful Revenue Cycle

People

- Are current skill sets aligned?
- Are job descriptions clear and reflective of current requirements?
- Are staff informed of leadership strategies?
- Have the staff been properly trained and assigned a mentor for success?
- Do you have a functional organizational structure with Key Revenue Cycle leaders?
- Does Leadership communicate expectations, opportunities and successes with the staff?
- Has structure been clearly communicated to staff?
Keys to a Successful Revenue Cycle

Process

- Do you have processes in place that support your policies and are they utilized?
- Do you have tangible cross functional flow charts for each major process?
- Do you clearly communicate each process, up stream and down stream?
- Are your processes based on your business objectives?
- Are the Revenue Cycle business objectives in line with the facilities strategies?
- Does leadership support the Revenue Cycle’s operating model and objectives?
Keys to a Successful Revenue Cycle

Process

- Do you have a “Daily Metric Driven” culture?
- Are pre planned KPI’s used in Daily, Weekly and Monthly operations to manage performance and process improvement?
- Do key leaders and staff understand how metrics drive performance?
- What metrics are used by leadership to communicate with Administration/Board members?
Keys to a Successful Revenue Cycle

Technology

- Does your current technology allow for best practice success?
- Are your processes clearly defined to maximize use of your technology?
- Do your current technology limitations define your process?
- Do you have steps in place to ensure that you are maximizing your current software platform?
- Is there support for updated technology and can it be operationalized to support People and Process?
The revenue cycle can be broken down into three key areas: Front-End, Mid-Cycle and Back-End.
Define Revenue Cycle

- Early problems in the cycle can have significant ripple effects further down the line.
- The further down the cycle the error travels the more costly revenue recovery becomes.
- Movement to push many of the traditional Back-End functions to the Front-End or Mid-Cycle.
Front-End

Patient Access
- Scheduling
- Pre-Registration
- Registration
- HIPAA

Financial
- Financial Counseling
- Insurance Eligibility
- Pre-Authorization
- POC Collection
Scheduling

- Responsible for finding the appointment time slot that best takes care of the patient’s medical needs.
- Verify that the patient understands the date and time selected.
- Have the patient supply pertinent demographic and insurance information.
- At a minimum obtain the patient’s name, date of birth and phone number.
- A single point for scheduling can help reduce errors and increase communication – centralized scheduling.
- First “moment of truth” - potentially lead to errors such as incorrect demographics or insurance information.
Scheduling

Opportunities

*People*:  
- Are your employees creating a positive first impression?  
- Are the schedulers good communicators with a “can-do” attitude?  
- Do the schedulers understand the business and how the time slots work?

*Process*:  
- Does your facility use a scheduling template?  
- Are physician orders available to scheduler at time of scheduling?  
- Are reminder calls placed to all patients?

*Technology*:  
- Is your scheduling system integrated with pre-registration?  
- Is the scheduling software enterprise-wide?  
- Does the scheduling software integrate clinical rules?  
- Does your facility have a sophisticated telephone system?
Scheduling

Key Performance Indicators

- Medical necessity checking at time of scheduling: 100%
- Average speed of call answer: < 30 seconds
- Percent inbound call abandonment rate: < 2%
- Next available appointment for diagnostic tests: < 24 hours
- Reminder calls for scheduled services: 100%
- Responsible for several components of the patient’s financial experience.
- Verify the patient’s identity as well as identify and correct any demographic variances which is required under HIPAA and “Red Flags Rules”.
- Ensures that applicable physician orders are in the patient’s medical record, and they are complete and legible.
- Performs benefit and eligibility verification.
- Obtains authorization of services from insurance carriers.
Opportunities

People:
- Are staff trained to interpret and understand the authorization response?
- Do staff have access and are they trained to navigate payor websites?
- Are staff completing the necessary tasks to promote positive patient experience?

Process:
- Does staff work exception reports to ensure accounts with discrepancies are corrected?
- Is staff ensuring all financial functions are completed prior to the scheduled patients arrival?

Technology:
- Does your facility utilize online/integrated insurance verification with real time response?
  Does the response back-feed the host system?
- Does the system allow for real-time editing to identify missing or inaccurate information that is required?
- Does your IT system and/or reports identify duplicate Master Patient Indexes (MPI)?
Key Performance Indicators

- Pre-registrations verified: 100%
- Pre-registrations certified; pre-authorized: >= 98%
- Scheduled patients pre-registered: 98%
- MPI duplication rate as a % of total registrations: < 1.0%
- Eligibility verified with payer for scheduled services: 98%
- Insurance verification is completed a minimum of 48 hours before the service is rendered and communicated with patient.
Registration / POS Collections

- On the edge where the hospital’s public face and back office meet.
- Responsible for several components of the patient’s financial experience.
- Identifies any patient prior balances past due for payment.
- Requests applicable patient deposits including copayment, deductible, coinsurance and prior balances.
- Conduct initial financial conversations with uninsured and underinsured patients, with referrals to financial counseling.
Opportunities

**People:**
- Do you have staff in place that are friendly and courteous to patients?
- Are staff provided feedback and required to correct their own registration errors?
- Do you have performance initiatives to promote job satisfaction and workforce stability?

**Process:**
- Are you conducting payment obligations and options for payment discussions with every patient?
- Is your staff initiating financial discussions and explaining point of service collections policies to patients?

**Technology:**
- Does your facility have online patient registration?
- Do you have any estimation tools for patient out of pocket responsibility?
- Are your registration and patient financial services systems integrated?
- Does your IT system identify claims on hold for registration errors?
Registration / POS Collections

Key Performance Indicators

- POS Collections as % of net revenue: 2.0 – 3.0%
- Registration accuracy: >95%
- Average registration duration: <= 10 minutes
- Average patient wait time: <= 10 minutes
- ABNs / MSPQs obtained when required: 100%
- % of claims on hold for registration errors: < 1/16 Day Revenue
- Number of statements returned in the mail weekly: < 5%
Financial Counseling

- Role is becoming more important with the increasing number of high deductible healthcare plans.
- Team is involved if the patient’s coverage is not in effect or will not cover the services scheduled.
- Challenged to hold conversations with patients in order to determine the source of payment for each episode of care.
- Highly visible and should be staffed accordingly.
- Outpatient, inpatient and emergency room (present during discharge).
- Also tasked to provide out of pocket expense estimates, collect payments and negotiate payment plans.
- Work very closely with scheduling.
Financial Counseling

Opportunities

People:
- Is the emergency department discharge area staffed with financial counselors?
- Are the staff compassionate and understanding with patients?

Process:
- Are all inpatients screened before discharge?
- Are your charity care policies complaint with federal, state, and local regulations (501r)?

Technology:
- Does the facility have electronic financial assistance applications with electronic signature?
- Do you have an electronic Medicaid application form with electronic signature?
- Does the financial counseling team have access to a document imaging system?
- Do you have patient estimation tools for determining out of pocket expenses?
Financial Counseling

Key Performance Indicators

- Medicaid eligibility screening for all uninsured patients: 100%
- Medicaid eligibility screening for all Medicare only patients: 100%
- % Uninsured ED patients screened for financial assistance: 80%
- % Uninsured IP and OP patients screened for assistance: 95%
- Collection of deposits for elective procedures prior to service: 100%
- Collection of inpatient balances prior to discharge: 65%
- Financial assistance approved within 10 days: 100%
- Medicaid approval obtained within 30 days: 100%
- Prompt-pay discount %: 5 to 20%
Mid-Cycle

Clinical
- Medical Documentation
- Quality Measures
- Patient Care

Charge Capture
- Chargemaster
- Coding
- Compliance
- Documentation
Case Management

- Vital function for hospitals.
- Assigned the task of monitoring admissions within clinical guidelines and intervening to provide coordination when needed.
- Performs care planning and coordination to ensure the discharge is not delayed due to preventable causes.
- Performs discharge planning.
- Increasingly important role with the complexities of hospital care.
- Dependent on access to real-time clinical data.
Case Management

Opportunities

People:
- Is the CM position staffed with professional nurses trained on the case management functions and responsibilities?
- Is your case manager included when selecting new case management applications or new ADT and clinical systems?
- Is the CM staff communicating effectively with all clinical departments involved in the patients care?

Process:
- Does the facility have clear guidelines governing the definition of what admission parameters are in the realm of reimbursable care?
- Do you have a process to identify observation cases approaching 24 hours?
- Are CMs notified of discharge cases that will require continued care?
- Is there an escalation process or alert process for discharge delays?
- Are patients equipped to effectively manage their disease at home?

Technology:
- Does your technology support real-time access to patient admission data?
- Does your facility utilize any case manager specific applications?
- Does your EMR contain automated rules for admission guidelines?
Case Management

Key Performance Indicators

- Observation cases with Length of Stay > 24 hours: 0%
- Cases denied due to inappropriate admission: 0%
- Cases with discharge delays by reason for delay: 0%
- Ratio of the length of stay actual to the expected average: 1 to 1
- Current admission population on SNF wait list: 0%
Charge Description Master

- Drives 100% of gross charges.
- Known as the chargemaster, charge description master or CDM.
- Built within a hospital information system.
- Comprehensive listing of items and services provided at a facility.
- Each item is assigned a unique identifier code.
- Contains items such as charge descriptions, revenue codes, CPT/HCPCS codes, prices.
- Vital to review, at least annually, to ensure compliance and accurate charge generation.
- Maintenance includes involvement from many areas and is therefore extremely complex.
# Charge Description Master

## Sample Chargemaster

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Dept Number</th>
<th>Description</th>
<th>Price</th>
<th>HCPCS Code</th>
<th>Revenue Code</th>
<th>Medicaid Code</th>
<th>GL Number</th>
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<tbody>
<tr>
<td>791002</td>
<td>761</td>
<td>Coronary Artery Dilation</td>
<td>$1,550</td>
<td>92982</td>
<td>481</td>
<td>92982TC</td>
<td>0800.4601</td>
</tr>
<tr>
<td>791000</td>
<td>761</td>
<td>Injection, Cardiac Cath</td>
<td>$220</td>
<td>93540</td>
<td>481</td>
<td>93540TC</td>
<td>0800.4601</td>
</tr>
<tr>
<td>761001</td>
<td>761</td>
<td>Nursing Fac Care, Subseq</td>
<td>$75</td>
<td>99307</td>
<td>636</td>
<td>7610</td>
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</tr>
<tr>
<td>761002</td>
<td>761</td>
<td>Home Visit, Patient</td>
<td>$80</td>
<td>99341</td>
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<tr>
<td>761003</td>
<td>761</td>
<td>Repair Eyelid Defect</td>
<td>$110</td>
<td>67915</td>
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<tr>
<td>810003</td>
<td>761</td>
<td>Repair Eyelid Defect</td>
<td>$550</td>
<td>67916</td>
<td>272</td>
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<td>0800.4601</td>
</tr>
<tr>
<td>810004</td>
<td>761</td>
<td>Removal of Kidney Stone</td>
<td>$390</td>
<td>50080</td>
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<tr>
<td>810050</td>
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<td>Decalcify Tissue</td>
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<tr>
<td>810061</td>
<td>761</td>
<td>Chromosome Count, Additional</td>
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<tr>
<td>810072</td>
<td>761</td>
<td>Assay of Free Thyroxine</td>
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</tr>
<tr>
<td>810080</td>
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<td>Assay of Thyroid Activity</td>
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<tr>
<td>791004</td>
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<td>272</td>
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<td>0800.4601</td>
</tr>
</tbody>
</table>
Opportunities

People:
- Does the CDM coordinator report to a chief revenue officer?
- Is the CDM coordinator an effective communicator?
- Does the CDM coordinator stay on top of published rules and regulations?

Process:
- Do you have a formal CDM change management process?
- Do you have a formal annual CDM review with each clinical department?
- Do you have a formal charge sheet/electronic entry review process?
- Is there a defensible pricing methodology for all items and services?
- Is there an overall CDM review completed annually either internally or by an outside firm?

Technology:
- Is the facility utilizing a third-party chargemaster software system?
Charge Description Master

Key Performance Indicators

- Duplicate items: 0
- Item price $0.0 other than “no-charge” services: 0
- Items with “Miscellaneous” as description: 0
- Item assigned an incorrect/ invalid CPT or HCPCS code: 0
- Item assigned incorrect/ invalid revenue code: 0
- All items have an understandable consumer description: Yes
- CDM requests completed within 2 business days: 100%
- Annual CPT and HCPCS changes in place by December 31 each year: Yes
Charge Capture / Documentation

- Essential tasks to capture information for billing.
- Important to ensure the record is complete and accurate with appropriate clinical detail.
- Can be extremely complex and subject to a wide degree of variation.
- Responsible for complete, accurate, and timely identification of charges.
- Responsible for complete, accurate and timely documentation of patient history, assessment, procedure notes, clinical plan and progress notes.
Opportunities

People:
- Are accountable parties supported with continuing education in charge criteria, coding and compliance guidelines?
- Are performance standards for charge capture and clinical documentation established?

Process:
- Is documentation readily available for use by HIM staff?
- Are providers documenting real-time or charting at the end of the day?
- Is there an escalation process when charges / documentation are not complete within the allotted timeframes?
- Are charges manually entered utilizing a charge entry application?
- Has your system implemented a Clinical Documentation Improvement Program?

Technology:
- Is your facility utilizing an EMR?
- Does the EMR contain rules for CCI, LCD and NCD edits up-front to warn clinicians with documenting procedures and diagnosis codes?
- Does the technology alert providers when they have a deficiency in their documentation?
- Do clinicians have the ability to e-sign records outside the hospital?
Key Performance Indicators

- Outpatient charges entered within one business day: 100%
- Late charge hold days: 2 days
- Charges entered for inpatient encounters < 7 days: 100%
- Percentage of late charges: 2.0%
- Percentage of lost charges: 1.0%
- Clinical documentation entered within one business day: 100%
- Final documentation signed < 3 business days: 100%
- Claims with charge coding errors, per scrubber: < 2%
- Claims with missing charges: < 2%
Health Information Management (HIM)

- Rely on access to clinical documentation.
- HIM staff may have to utilize varying tools and applications.
- Responsible for complete, accurate, and timely coding of clinically documented care and patient conditions.
- Review documentation to ensure compliance with financial and regulatory guidelines.
- Coding staff requires access to ALL areas of clinical documentation in the paper chart or EMR.
Opportunities

People:
- Are HIM staff involved in EMR planning activities?
- Are coding staff required to stay current on coding guidelines?
- Are all coders certified and maintain certification CPEs?

Process:
- Is there a formal process in place to query providers for additional information or clarification?
- Are operational controls in place to monitor performance of coding tasks?
- Is workload divided equally among coding staff?
- Are internal quality control audits performed at least quarterly?
- Are external quality control audits performed at least annually?

Technology:
- Does your facility employ coding specific system tools, such as an encoder?
- Do HIM staff have access to reference materials?
- Are edits applied to coded clinical data prior to claims submission?
- Is the DRG grouper integrated with the HIS software?
- Are scanned images indexed by encounter by provider?
Key Performance Indicators (Outcome Measures)

- DN FB Work in Process as % of Revenue or days in A/R: 5%
- Days from date of service or discharge to final coded: 3
- Coding status incomplete > 5 days as a % of total cases: 5%
- Coding denials as % of total accounts and total charges: 1%
- Coding write-offs as a % of total accounts and total charges: 1%

Key Performance Indicators (Productivity Measures)

- Inpatient charges coded per coder/ per day: 20 - 23
- Observation charts coded per coder / per day: 30 - 34
- Outpatient charts coded per coder / per day: 150 - 210
- Emergency Department charts coded per coder / per day: 150 - 210
Additional Operational Controls

- List of discharges pending completion of documentation, by provider, with aging.
- List of cases pending completion of coding, by coder, with aging.
- Report of incomplete cases > 5 days from discharge.
Claims and Billing
- Pricing
- Claims Editor
- Submission
- Adjustments

Payment
- Reimbursement
- Denials and Appeals
- Receivables
- Collections
Foundation of a facilities cash flow.

Overall performance relies heavily on a strong performance from the front-end and mid-cycle.

Smooth operation relies on having strong processes and information technology solutions in place.

With a high claim volume, automation is a must.

System goal is to produce a “clean claim”.
Billing and Claims Submission

Opportunities

People:
- Are staffing levels sufficient to minimize backlogs?
- Are quality standards part of a billers job description?
- Does your organization provide performance-based incentive?
- Are billers cross-trained on more than one payor type?

Process:
- Do you perform regular quality control reviews of biller’s work?
- Are biller specific work lists or queues utilized?
- Do you perform biller-specific productivity and error reporting?
- Do you perform departmental error tracking and feedback?

Technology:
- Are major payor edits supplied and/ or supported by the vendor?
- Does the system allow flexibility to add internal edits?
- Can the system perform automated secondary payor claim submission?
Billing and Claims Submission

Key Performance Indicators

- HIPAA compliant electronic claims submission rate: 100.0%
- Final-billed / claim not submitted backlog (in A/R Days): 1.0
- Medicare Return to Provider rate (RTP): 3.0%
- Overall claim denial rate (% of total claims submitted): <5.0%
- Denial write-offs (% of monthly net revenue): <3.0%
- Clean claim submission rate: >85.0%
Cashiering, Refunds, Adjustments

- Focus on processing reimbursement.
- Manage incoming claim responses from all payers.
- Vital to ensuring payments are accurate.
- Can play a key role in routing of denied claims to appropriate review team.
- Relies heavily on technology for automation of high volume processes.
Opportunities

People:
- Are cashiering and refund duties performed by dedicated staff with no other duties?
- Are quality and quantity performance standards part of the job duties?
- Are staff trained on more than one payor type?

Process:
- Is a lockbox utilized for all non-electronic payments?
- Is remit payment data posted daily?
- Are denial transaction codes entered into the system and tracked?
- Are contractual adjustments posted at time of final billing?
- Are cash receipts credited or deposited on day received?

Technology:
- Is your organization able to accept ANSI 835 electronic claims payments?
- Does your facility utilize a contract management system to monitor accuracy of payments?
Cashiering, Refunds, Adjustments

Key Performance Indicators

- HIPAA compliant electronic payment posting %: 100.0%
- Transaction posting backlog (in business days): 1.0
- Credit balance A/R days (gross charge in A/R days): <1.0
Third-Party Follow-Up

- “Workhorse” of the revenue cycle.
- Functions as a clean up crew for poor front-end and mid-cycle processes and mishandled claims.

- While front-end and mid-cycle processes may improve, claims follow-up will remain a necessary function.
- Can be managed in-house or outsourced.
Third-Party Follow-Up

Opportunities

People:
- Are staffing levels sufficient to minimize A/R build-up?
- Are quality and quantity standards part of the job description?
- Are staff cross trained on more than one payor type?

Process:
- Are regular quality control reviews performed?
- Are collector specific work lists utilized?
- Are proper controls in place for write-offs and bad debt?
- Is a root cause analysis performed on denial/underpayment trends?
- Are regular meetings held to review high dollar/high risk/high delinquency accounts?

Technology:
- Is there a dual directional interface for collection notes into the HIS?
- Are collectors utilizing on-line, web-enabled third-party payer inquiry systems?
- Are automatic system reminders in place for each stage of follow-up on outstanding claims?
Third-Party Follow-Up

Key Performance Indicators

- A/R aged more than 90 days: 15.0 – 20.0%
- A/R aged more than 180 days: 5.0%
- A/R aged more than 365 days: 2.0%
- Bad debt write-off as % of gross revenue: 3.0%
- Charity write-offs as % of gross revenue: 2.0%
- Cost – to – collect (expenses / cash): 3.0%
- DNFB A/R days: < 8.0
- Net A/R days: < 50.0
Customer Service

- Essential business function for any healthcare organization.
- Can be related closely to patient registration in terms of metrics.
- Responsible for timely and accurate resolution of patient account issues and inquiries.
- Requires a wide-ranging knowledge of the revenue cycle.
- Coordinates with many other areas of the revenue cycle for issue resolution.
Customer Service

Opportunities

People:
- Do staff promote a strong patient service oriented culture?
- Are staff able to adequately navigate information systems to resolve account inquiries?
- Are individual productivity standards established?
- Is customer service a dedicated team with no other job duties?
- Are staff cross trained in more than one payor type?

Process:
- Are there defined steps and communication channels with other departments to resolve account issues?
- Do staff have access to real-time, accurate information within the patient account?
- Are work lists created for account follow-up?
- Are regular quality control reviews performed?

Technology:
- Does the telecom system have a robust Automated Call Distribution (ACD) reporting system?
- Is the ACD integrated with the facilities’ existing information system?
- Are web-based systems in place for patients to request information and itemized bills?
Customer Service

Key Performance Indicators

- Correspondence backlog from day of receipt: <= 1 day
- Walk-in patients’ wait time in minutes: <= 5.0
- ACD system average hold time in minutes: <= 0.5
- ACD system abandoned call percentage: <= 2.0%
- ACD system percentage of calls resolved in <= 5 minutes: >= 85.0%
- ACD system percentage of calls not resolved in < 10 mins: <= 5.0%
- Calls resolved in customer service w/ out complaint or referral to Administration: >= 99.0%
Collections and Outsourcing

- Normal part of day-to-day business operations in healthcare.
- Historically, providers have relied upon external collections vendors – primarily for resolution of bad debt accounts.
- Many vendors are also starting to offer more extended business office functions.
- Information technology plays a critical role in the relationship between a provider and a collections vendor.
Collections

Opportunities

People:
- Is the vendor willing to provide their own employees on-site as needed?
- Are dedicated employees assigned to each provider’s account?
- Are performance goals defined and tracked on a routine basis?

Process:
- Is there a clear process for the bi-directional transfer of accounts between the vendor and provider?
- Is there a propensity-to-pay methodology in place?
- Are you utilizing more than one bad debt agency?

Technology:
- Is an automated billing and collections system utilized?
- Do you have direct integration of billing, collections and posting system functions?
- Does your organization have access to the vendors system for reporting?
- Does the software system allow for automatic prioritization of accounts?
Key Performance Indicators

- Bad debt net-back collection percentage: >=11.0%
- Extended business office fee as % of collections: 15.0-18.0%
- Self-pay extended business office fee as % of collections: 6.0-12.0%
- Medicaid eligibility assistance fee as % of collections: 15.0-18.0%
- Routine auditing of collection agency work standards: Every 60 days
Summary
The Keys to Revenue Cycle Success
Summary

- Having the right people in the right function will allow for a high functioning revenue cycle.
- Clearly defined processes will result in an optimized and efficient revenue cycle.
- Technology is vital to the success of the healthcare revenue cycle.
- Definable and measurable key performance indicators contribute to optimal performance.