



**Health Care Revenue Cycle
Management Session
CMS I/T/U Training – ABQ Area**

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Mission of the 3rd Party Revenue Cycle

**“Raising Community Health Status
By Effective Third-Party Revenue
Management within Healthcare
Facilities to provide safe and quality
healthcare to patients.”**



3rd Party Revenue Cycle

- **Team Approach**
- **What are the Roles that contribute to the Revenue Generation Cycle?**
- **Disruptions in the Revenue Cycle**
- **Establishing Rules**
- **Compliance**
- **Benefits of Successful Implementation**
- **Revenue Reports**
- **Third Party Revenue -up 1/2 half of total operating budget.**



Revenue Generation Cycle

**Walk-In /
Appointed
Patient**



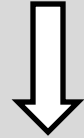
**Triage
Nurse**



**Patient
Registration**



**Benefits
Coordination**



**Data
Entry**



**Medical
Records**



Coding



**Provider
Services**



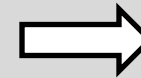
Collections



Billing



**Accounts
Receivable**



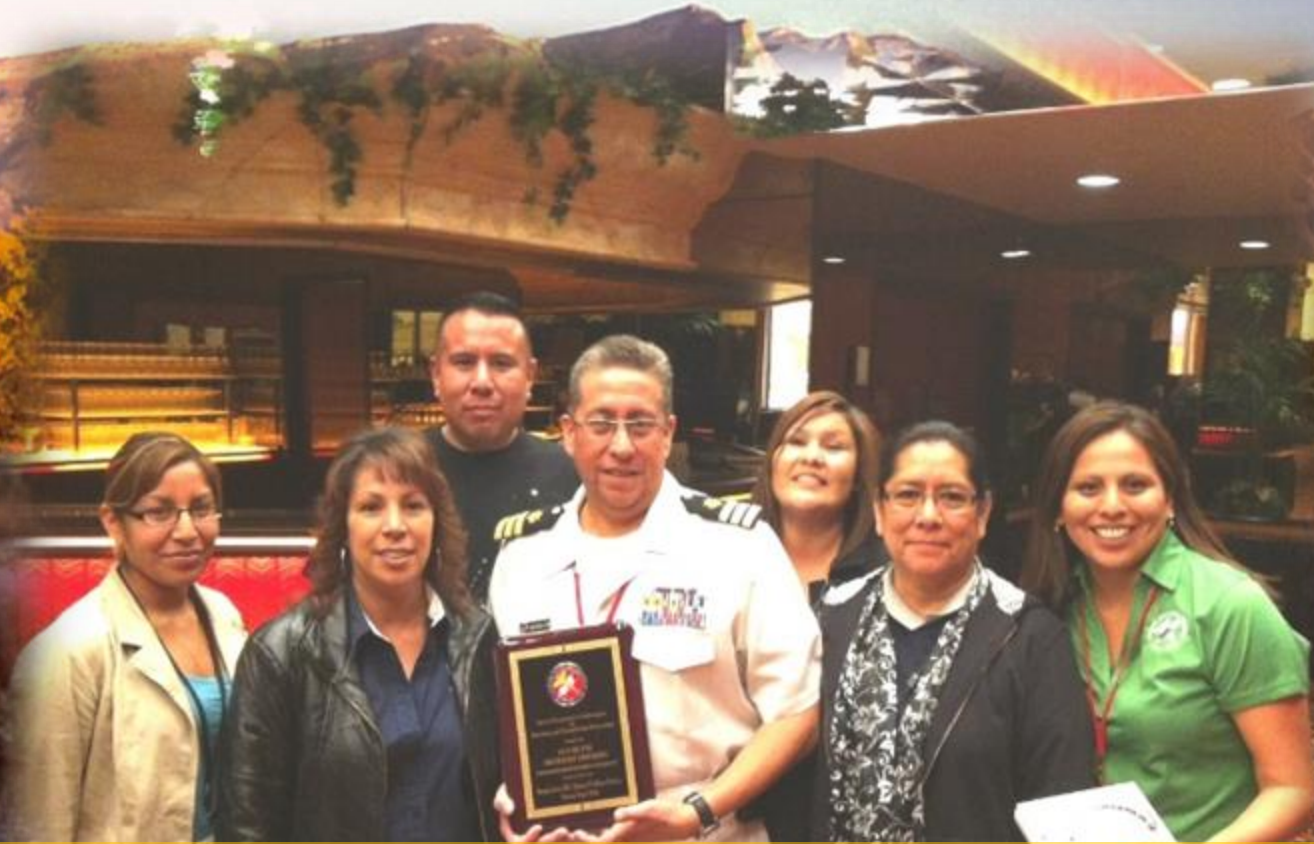
**Financial
Management**



Management



Team Approach

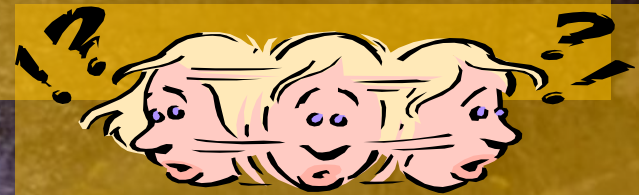


**10-13 Individuals/Interactions/Functions
to Generate \$1 for your facility.**



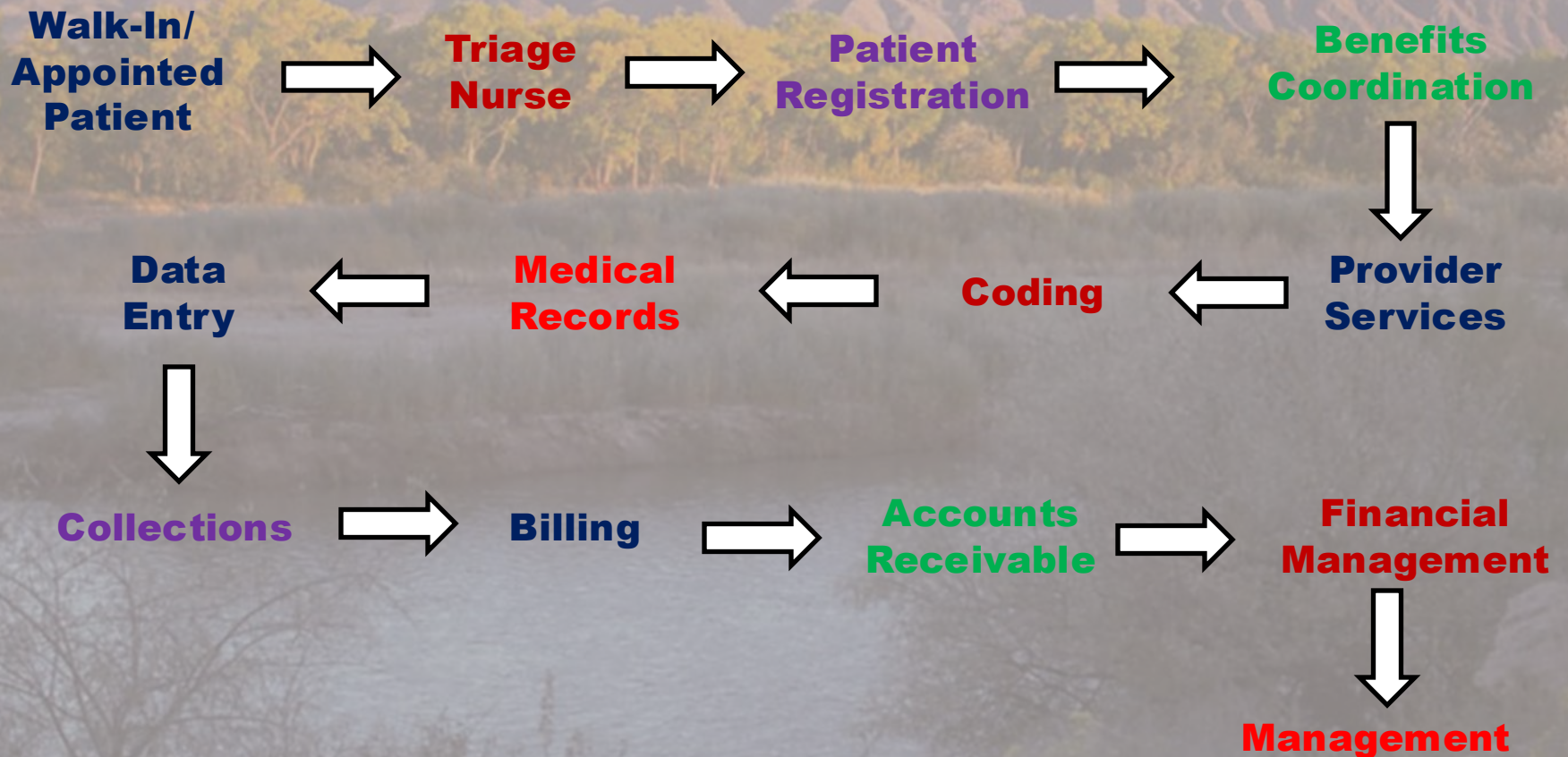
Revenue Cycle Misconception

- “Business Office Revenue”
- “It’s Magic” or “Push the button and revenue flows in”
- “It’s not my job. I provide health care, not here for administrative duties.”
- “The Business Office generates Revenue.”
- “If the Business Office is backlogged, pressure them to increase revenue.”





Individual Functions?





Triage

- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Triage Nurse assesses situation. Urgent? Emergent?
 - Date, Time, Vital Signs, Chief Complaint, Clinic Code documented.
 - May identify preventive services and opportunities of care.
 - Triage Nurse may be the first to see the patient, and may initiate the “Check-In” process, which will generate an EHR visit in order to document a potentially billable visit.





Patient Registration

- PERTINENT REVENUE CYCLE RESPONSIBILITIES:
 - Interview patient obtain identifying demographic and eligibility information.
 - Verify third party eligibility information.**
 - Obtain required patient signatures and documents
 - Responsible for obtaining pre-certification (approval) for certain procedures or hospital admissions.
 - Refer Patient to Benefits Coordinator when necessary.
 - If this is the first point of contact, the “Check In” process can be initiated at this time.
 - Promotes positive image for the entire patient visit.
 - Can “make or break” a positive health care experience.





Benefits Coordination

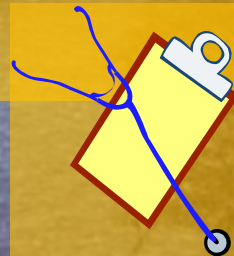
- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Determine patient is eligibility for “not yet identified” alternate resource program. (NM Medicaid largest payer).
 - Liaison between facility, patient, State and Federal Agencies.
 - Patient advocate for scheduling appointments and follow up with alternate Resource Programs.
 - Many ACA Medicaid and Marketplace programs can be applied on-line now. BeWellNM.com
 - Explain benefits of alternate resources to the patient.
 - Beneficial to both hospitals and ambulatory facilities in increasing revenue.





Providers

- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Provide Services, distribute meds and supplies.
 - Document ALL services properly.
 - Meet legal and billing requirement with proper documentation.
 - Complete documentation in a timely manner.
 - Can be *challenging* at times for HIM and the Business Office
 - Include E/M coding requirements (History, exam, medical decision making, supplies given, labs/x-rays orders, meds prescribed, education, consultations, etc.)





Coding

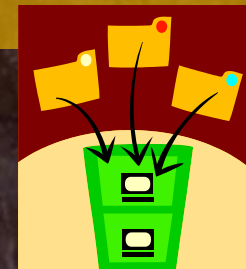
- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Certified Coder is essential to the revenue cycle
 - Providers trust the Certified Coder to translate the documentation into billable codes on their behalf and on behalf of the facility.
 - Every Diagnosis, Procedure and Supply is coded according to the ICD-10 and HCPCS (CPT) guidelines.
 - Codes are written or verified directly on the encounter form.
 - Incomplete/inaccurate encounter visit information returned to the provider PRIOR to next step, Medical Records/HIM.
 - Communicate and educate Provider to enhance documentation and data integrity.





“Medical Records/HIM

- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Ensure that the EHR Visit data/encounter form is properly completed or filed.
 - Continuity of Care - Charts must be properly maintained to ensure access to all “need to know” parties.
 - Legal requirements
 - Medical Records responds to most Third-Party Payer correspondence. (ROI)
 - Third Party Payers may require more information
 - before adjudicating a bill (inpatient docs,
 - nursing notes, etc.)





Billing

- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Know and apply all billing/payer requirements and rules to each individual claim before approved.
 - “Check point” to validate accuracy of the coding.
 - Sequence and link all proper diagnosis and procedures to ensure payment.
 - Approve and submit “Clean Bills” to Third Party Payers.
 - Serve as Final Check Point, ONLY billing for documented services, and billing for ALL documented services.
 - Should be billing electronically





Collection Process

- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Process Checks as received at the facility
 - Process Electronic Funds Transfers (avoidance of paper checks)
 - Enter all Receipts into Accounts Receivable System for further processing and reconciliation.
 - Receive EOB or download the ERA and Collection Register to give to Accounts Receivable Department.
 - Prepare Deposit Slip (or similar document) and submit to Finance for processing.
 - Responsible for any refunds.





“Financial Management

- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Responsible for the actual deposit of any revenue collected at the facility. (Lockbox)
 - Reconcile with Bank if Direct Deposit (Electronic Funds Transfer) is used.
 - Ensure proper accounting for each source of Revenue
 - Make sure that each department or program has access to the revenue that the facility has earned.
 - Prepare and distribute the Advice of Allowance for facility management, leadership, and the Board.
 - Assist in Monthly reconciliation of Collections Received.





Accounts Receivable

- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Responsible for completion (close out) of all Patient Account Receivables.
 - Post all receipts of Payments, Denials, and Adjustments to Accounts Receivable System.
 - Analyze receipts to determine when and if Third Party Payers need to be “questioned” on their decision of payment.
 - Perform follow up (phone calls, correspondence, etc.) on all unpaid claims and aging receivables.
 - Make the determination as to whether or not a “secondary” payer should be billed.
- **Provide feedback to providers showing revenue being generated!**





Management

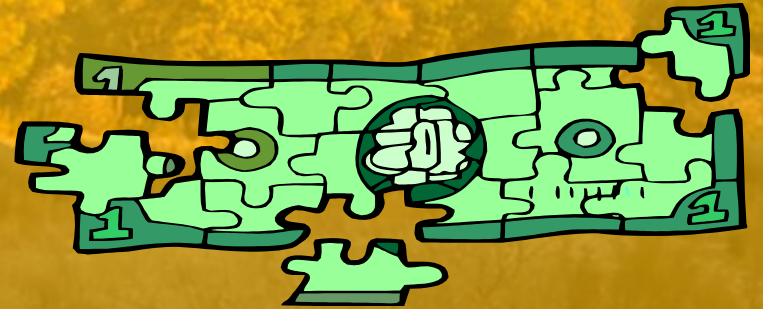
- FUNCTIONS/RESPONSIBILITIES PERTINENT TO REVENUE CYCLE:
 - Management has overall responsibility to ensure the “Revenue Cycle” is not broken.
 - Decisions made to process changes if Revenue Cycle is broken, e.g., lack of training, staffing shortages, IT enhancements, etc.
 - Must have an understanding and support the entire revenue generation cycle.
 - Ensure necessary staff, space, training, and equipment is provided to “maximize revenue”.





Disruptions in Revenue Cycle

- What happens if a process does not work or there is a disruption in the cycle?
 - Delayed Cash Flow
 - Potential Lost of Revenue
 - Unnecessary Rework
 - Inefficient and Ineffective Patient and Workflow
 - Staff competency or conduct issues could be an issue
 - Review your Internal Control processes for your facility.





INTERNAL CONTROLS REVENUE CYCLE ASSESSMENT

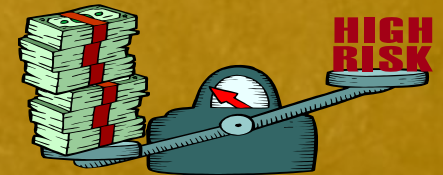
DATE:

| FUNCTION | DOCUMENTATION/REVIEW | FINDINGS | ASSIGNED | TIMELINE |
|--|---|----------|----------|----------|
| 1. FACILITY SPECIFIC PROCEDURES | | | | |
| 1A. Patient Registration | <ul style="list-style-type: none">⇒ Verify that written facility procedures exist for each of the functions.⇒ Flowchart process documenting names of responsible person as well as back-up staff⇒ Sample work for evidence of compliance with the flowchart | | | |
| 1B. Benefit Coordination | <ul style="list-style-type: none">⇒ Verify that written facility procedures exist for each of the functions.⇒ Flowchart process documenting names of responsible person as well as back-up staff⇒ Sample work for evidence of compliance with the flowchart | | | |
| 1C. Coding/Data Entry | <ul style="list-style-type: none">⇒ Verify that written facility procedures exist for each of the functions.⇒ Flowchart process documenting names of responsible person as well as back-up staff | | | |



High Risk Areas

- No Chief Complaint
- No History or Review of Systems (or notation to where to find it in the chart)
- Cannot Bill Using Rule Out
- Using Follow Up (F/U) without another Diagnosis
- Subjective/Objective: “See Above” and there is nothing listed in the Chief Complaint.
- Physicians/Nurses Prescribing or Ordering own meds and labs
- Med Refill Visits (V68.1 only)
- ER Visits without Vitals
- Ancillary Services Ordered without Medical Necessity, or ANY Diagnosis
 - Lab
 - X-Ray (Chest X-Ray for Depression)
- Administrative Encounter/Phone Calls coded as Clinic Visits
- 1 Day Inpatient Admissions – RED FLAG
- Lack of use of Observation Status
- E/M Coding – up coding/same E/M level for all services
- Lack of Medical Necessity Documentation
- Lack of Inpatient documentation (H&P, Discharge summary, etc.)
- Unbundling
- **FAILURE TO ADDRESS THESE COULD LEAD TO FRAUD AND BEING AUDITED (OIG, CMS, etc.)**





Benefits of Successful Implementation

- Enhancement and Protection of entire Third-Party Resource Program
- Accurate/Complete Medical Documentation
- Enhanced Provider Profiling Capabilities
- Reduced malpractice/tort action liability
- Improved Risk Management for Physicians and Hospitals
- Facilitated Quality Assurance/Accreditation mandates
- Cost Accounting/Reporting Capabilities
- COMPLIANCE with Rules and Regulations
- Third Party Resource Maximization
- Quick Access of needed information
- INCREASED REVENUE, EXPANSION OF SERVICES, AND IMPROVED QUALITY OF CARE





Revenue Reports

Reports in order to track your revenue cycle:

PSR – Period Summary Report

ASM – Age Summary Report

ADJ – Adjustment Report

BRRP – Brief Claims Listing Report

EHRD – Coding (backlogs, payer type, incomplete visits, queue)

BSL – Batch Statistical Listing

AOI – Age Open Items Report

OPS – Operations Summary

DAY – Days Cash on Hand

RPT – Patient Registration report (payer mix, veterans, etc.)

BCP – Patient Benefits Coordinator Reports

TRE – Trending Reports on Revenue flow and projections

3PTM – Third Party Insurer File Menu

EDFE – Fee Schedule Maintenance

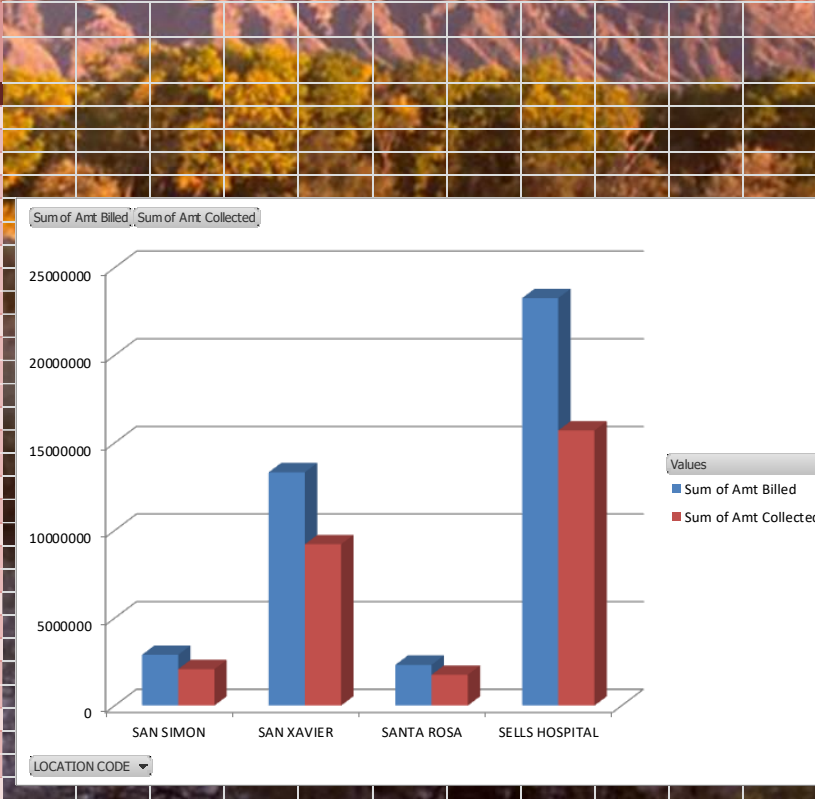




Revenue Reports – Billed Collections Visit Data

Tucson Area Indian Health Service - FY 2012 (October 2011 - September 2012)

| Row Labels | Sum of # Vst | Sum of # Pts | Sum of Amt Billed | Sum of Amt Collected |
|-----------------------------|--------------|--------------|-----------------------|-----------------------|
| AMBULANCE | 867 | 650 | \$1,178,916.85 | \$473,851.96 |
| SELLS HOSPITAL | 867 | 650 | \$1,178,916.85 | \$473,851.96 |
| ANTICOAGULATION | 131 | 11 | \$31,310.94 | \$27,576.13 |
| SAN XAVIER | 131 | 11 | \$31,310.94 | \$27,576.13 |
| ANTICOAGULATION THER | 130 | 14 | \$26,227.17 | \$22,776.49 |
| SELLS HOSPITAL | 130 | 14 | \$26,227.17 | \$22,776.49 |
| AUDIOLOGY | 32 | 28 | \$9,789.00 | \$6,244.71 |
| SAN XAVIER | 0 | 0 | \$0.00 | \$0.00 |
| SELLS HOSPITAL | 32 | 28 | \$9,789.00 | \$6,244.71 |
| BEHAVIORAL HLTH | 139 | 96 | \$36,158.41 | \$22,067.61 |
| SAN XAVIER | 121 | 80 | \$30,517.41 | \$19,055.23 |
| SANTA ROSA | 2 | 2 | \$588.00 | \$294.00 |
| SELLS HOSPITAL | 16 | 14 | \$5,053.00 | \$2,718.38 |
| CARDIOLOGY | 155 | 112 | \$36,374.19 | \$25,419.63 |
| SAN XAVIER | 20 | 16 | \$5,226.79 | \$3,850.18 |
| SELLS HOSPITAL | 135 | 96 | \$31,147.40 | \$21,569.45 |
| CASE MANAGEMENT SER | 0 | 0 | \$0.00 | \$0.00 |
| SAN XAVIER | 0 | 0 | \$0.00 | \$0.00 |
| CHEST AND TB | 10 | 6 | \$1,996.60 | \$843.67 |
| SAN XAVIER | 1 | 1 | \$54.60 | \$54.60 |
| SELLS HOSPITAL | 9 | 5 | \$1,942.00 | \$789.07 |
| COMPUTED TOM | 0 | 0 | \$0.00 | \$0.00 |
| SAN XAVIER | 0 | 0 | \$0.00 | \$0.00 |
| CRIPPLED CHI | 1 | 1 | \$1,584.00 | \$0.00 |
| SAN XAVIER | 0 | 0 | \$0.00 | \$0.00 |
| SELLS HOSPITAL | 1 | 1 | \$1,584.00 | \$0.00 |
| DAY SURGERY | 42 | 24 | \$45,439.76 | \$9,888.09 |
| SAN XAVIER | 1 | 1 | \$294.00 | \$294.00 |
| SELLS HOSPITAL | 41 | 23 | \$45,145.76 | \$9,594.09 |
| DENTAL | 9,523 | 3,803 | \$3,021,908.40 | \$1,791,948.98 |





Revenue Reports – Aged Accounts

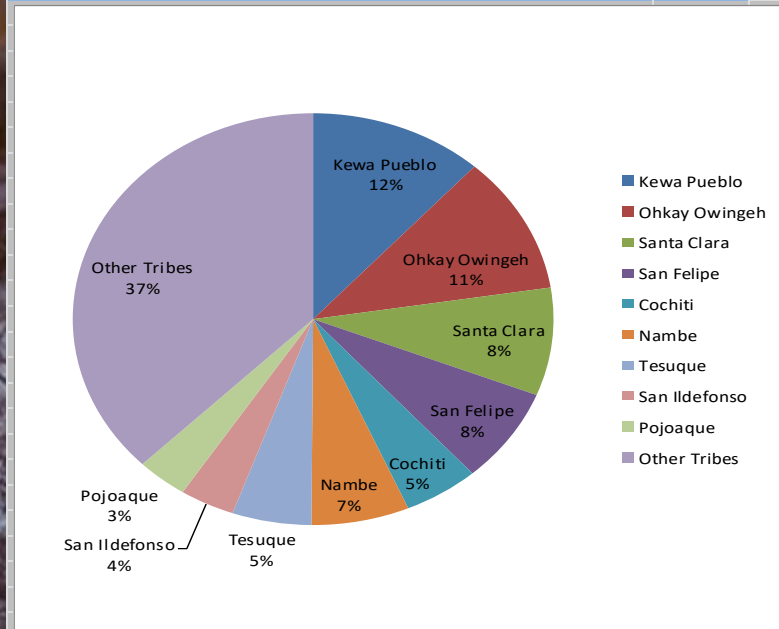
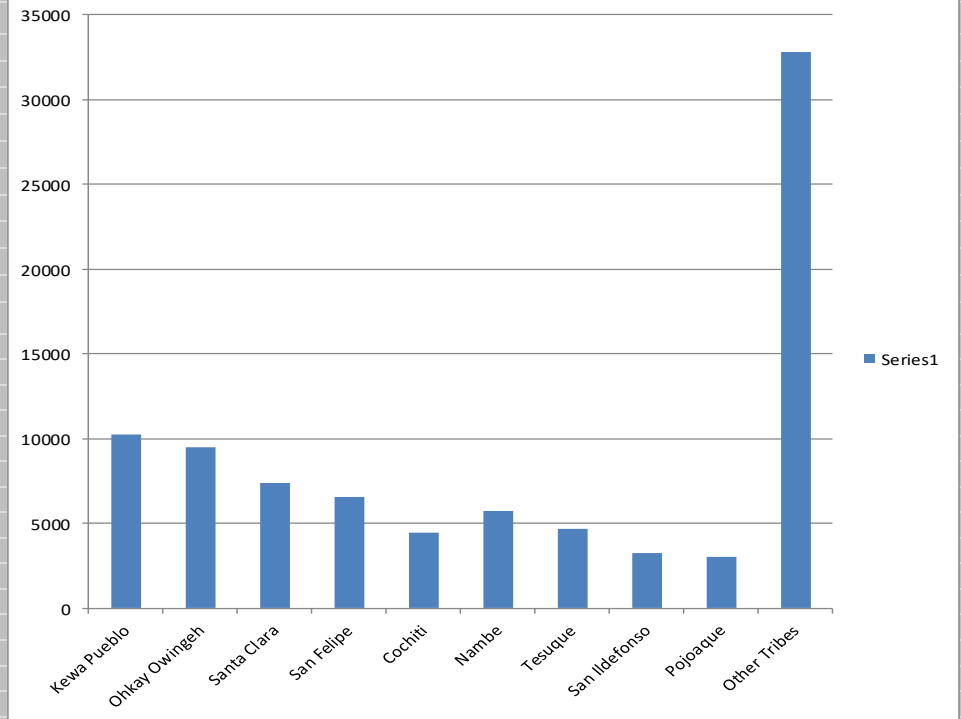
| | | Accounts Receivable Aging | | | | | | | | | | | |
|-------------------|------------------------|---------------------------|----------------------|---------------|----------------------|---------------|----------------------|---------------|----------------------|--------------|-----------------------|---------------|---------|
| | | | | Feburary | | 29 | | 2016 | | | | | |
| S/U | Total A/R | Current | | 31-60 | | 61-90 | | 91-120 | | 120+ | | | |
| ASU | | | | | | | | | | | | | |
| VA | \$ 26,734.25 | \$26,734.25 | | 0.00% | | 0.00% | | 0.00% | | 0.00% | | \$ 26,734.25 | 100.00% |
| Medicaid | \$ 686,253.31 | \$686,253.85 | \$ 224,044.09 | 32.65% | \$ 61,157.29 | 8.91% | \$ 27,953.18 | 4.07% | \$ 54,274.30 | 7.91% | \$ 318,824.45 | 46.46% | |
| Medicare | \$ 1,874,218.97 | \$1,874,219.41 | \$ 355,150.66 | 18.95% | \$ 260,350.56 | 13.89% | \$ 141,898.41 | 7.57% | \$ 61,343.94 | 3.27% | \$1,055,475.40 | 56.32% | |
| Private Insurance | \$2,988,963.40 | \$2,988,963.79 | \$ 395,717.37 | 13.24% | \$ 383,693.49 | 12.84% | \$ 206,868.95 | 6.92% | \$ 166,290.33 | 5.56% | \$1,836,393.26 | 61.44% | |
| Other | | #DIV/0! | | #DIV/0! | | #DIV/0! | | #DIV/0! | | #DIV/0! | | #DIV/0! | #DIV/0! |
| ASU Total | \$ 5,576,169.93 | \$5,576,169.93 | \$ 974,912.12 | 17.48% | \$ 705,201.34 | 12.65% | \$ 376,720.54 | 6.76% | \$ 281,908.57 | 5.06% | \$3,237,427.36 | 58.06% | |
| ACL | | | | | | | | | | | | | |
| VA | \$ 12,978.57 | \$12,979.57 | \$ 2,890.52 | 22.27% | \$ 7,352.87 | 56.65% | \$ 1,287.09 | 9.92% | \$ 1,448.09 | 11.16% | \$ - | 0.00% | |
| Medicaid | \$ 172,915.21 | \$ 172,916.09 | \$ 121,401.87 | 70.21% | \$ 15,483.40 | 8.95% | \$ 8,528.72 | 4.93% | \$ 5,997.53 | 3.47% | \$ 21,503.69 | 12.44% | |
| Medicare | \$ 551,187.16 | \$ 551,187.87 | \$ 224,472.67 | 40.73% | \$ 65,453.58 | 11.88% | \$ 70,367.84 | 12.77% | \$ 28,910.40 | 5.25% | \$ 161,982.67 | 29.39% | |
| Private Insurance | \$468,317.51 | \$468,318.10 | \$ 164,044.50 | 35.03% | \$ 64,183.97 | 13.71% | \$ 28,675.44 | 6.12% | \$ 17,754.74 | 3.79% | \$ 193,658.86 | 41.35% | |
| Other | \$ 29,490.53 | \$29,490.70 | \$ - | 0.00% | \$ 1,911.00 | 6.48% | | 0.00% | \$ 3,017.00 | 10.23% | \$ 24,562.53 | 83.29% | |
| ACL Total | \$ 1,234,888.98 | \$1,234,888.98 | \$ 512,809.56 | 41.53% | \$ 154,384.82 | 12.50% | \$ 108,859.09 | 8.82% | \$ 57,127.76 | 4.63% | \$ 401,707.75 | 32.53% | |
| RTC | | | | | | | | | | | | | |
| Medicaid | \$ 97,764.71 | \$97,764.99 | \$ 18,600.00 | 19.03% | \$ 9,000.00 | 9.21% | \$ - | 0.00% | \$ - | 0.00% | \$ 70,164.71 | 71.77% | |
| Medicare | | \$0.00 | | | | | | | | | | | |
| Private Insurance | \$52,500.00 | \$52,501.00 | \$ - | 0.00% | \$ - | 0.00% | \$ 52,500.00 | 100.00% | \$ - | 0.00% | \$ - | 0.00% | |
| RTC Total | \$ 150,264.71 | \$150,264.71 | \$ 18,600.00 | 12.38% | \$ 9,000.00 | 5.99% | \$ 52,500.00 | 34.94% | \$ - | 0.00% | \$ 70,164.71 | 46.69% | |



Revenue Reports – Visit Data/Third Party Data

Santa Fe Service Unit - Total Visits by Tribal Affiliation (Hospital Only) - FY 2015

| Tribes | Visits |
|---------------|--------------|
| Kewa Pueblo | 10254 |
| Ohkay Owingeh | 9483 |
| Santa Clara | 7408 |
| San Felipe | 6534 |
| Cochiti | 4428 |
| Nambe | 5769 |
| Tesuque | 4665 |
| San Ildefonso | 3229 |
| Pojoaque | 3008 |
| Other Tribes | 32776 |
| Total: | 87554 |





Revenue Reports – Adjustments

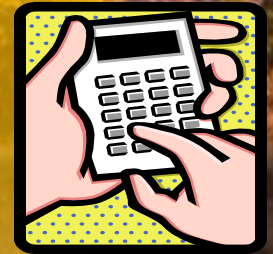
FY2014 Tucson Area Adjustment Reason Report October 2013 - September 2014

| Sum of TOTAL ADJUSTMENTS | Column Labels | | | | | |
|-------------------------------------|---------------|---------------|---------------|---------------|----------------|-----------------|
| Row Labels | AMBULANCE | SAN SIMON | SAN XAVIER | SANTA ROSA | SELLS HOSP | Grand Total |
| MEDICAID | \$ 45,062.92 | \$ 144,127.92 | \$ 478,201.60 | \$ 102,276.78 | \$ 971,232.09 | \$ 1,740,901.31 |
| Chrgs DoNotMeet Criteria ER/UC | \$ 1,197.00 | \$ 3,710.00 | \$ 18,888.00 | | \$ 11,766.00 | \$ 35,561.00 |
| Chrgs Excd Contract Fee Arrngmt | \$ 5,220.92 | \$ 20,823.70 | \$ 2,443.70 | \$ 885.60 | \$ 59,795.87 | \$ 89,169.79 |
| Chrgs Excd Max Allowable Amt | | | \$ 135.27 | \$ 179.57 | \$ 1,475.09 | \$ 1,789.93 |
| Claim Denied Charges | \$ 4,116.00 | \$ 660.00 | \$ 5,304.00 | \$ 10,572.00 | \$ 114,786.00 | \$ 135,438.00 |
| Claim Pending FurtherReview | | | | | \$ - | \$ - |
| Clm Den Pt Not Identif Isurd | | | \$ 2,640.00 | | \$ 330.00 | \$ 2,970.00 |
| Clm Lacks Prior Pymt Info | | | | \$ 660.00 | | \$ 660.00 |
| Clm spans elig/inelg cov-rebi | | | | \$ 330.00 | | \$ 330.00 |
| Clm/Srv Rej Info Incomplete | | | | | \$ 165.00 | \$ 165.00 |
| Clm/Srv Lacks Info For Adjud | \$ 4,452.00 | \$ 41,016.00 | \$ 209,740.00 | \$ 38,232.00 | \$ 193,113.00 | \$ 486,553.00 |
| Code Err DX Inconst w Pt Ag | | | \$ 330.00 | | | \$ 330.00 |
| Code Err DX Inconst w Pt Gdr | | \$ 58,154.60 | \$ 70,402.00 | \$ 27,858.00 | \$ 90,864.00 | \$ 247,278.60 |
| Code Err Proc Inconst w ProvTp | | | | \$ 1.00 | | \$ 1.00 |
| Code Err Proc Inconst w Pt Age | | \$ 35.84 | \$ 330.00 | | | \$ 365.84 |
| Code Err Proc Inconst w Pt Gdr | | | \$ 1,320.00 | | \$ 672.00 | \$ 1,992.00 |
| CODING ERROR | | | | | \$ 684.00 | \$ 684.00 |
| Coinsurance Amount | | | \$ (10.98) | | | \$ (10.98) |
| Contractual Adjustment | | | \$ 342.00 | | | \$ 342.00 |
| Co-Payment Amount | | | | \$ 35.00 | | \$ 35.00 |
| Coverage Not in Effect on DOS | | | | | \$ 342.00 | \$ 342.00 |
| CREDIT FROM OTHER BILL | | \$ 330.00 | \$ 6,179.98 | \$ 1,784.20 | \$ 27,492.27 | \$ 35,786.45 |
| CREDIT TO OTHER BILL | | \$ (468.77) | \$ (3,381.60) | \$ (1,332.00) | \$ (34,397.43) | \$ (39,579.80) |
| Death Precedes Date of Service | | | \$ 330.00 | | | \$ 330.00 |
| Duplicate Claim/Service | \$ 21,173.00 | \$ 4,106.02 | \$ 4,623.23 | \$ (6,897.90) | \$ 38,827.15 | \$ 61,831.50 |
| DX is Not Covered | | \$ 2,640.00 | \$ 10,608.00 | | \$ 16,890.00 | \$ 30,138.00 |
| Dx not Covered Missing Invald | | \$ 342.00 | | | | \$ 342.00 |



Other Revenue Considerations

- **How care is delivered**
 - Patient Centered Medical Home Model
 - Pharmacy POS (a big potential to increase revenue)
 - Consolidated Mail Order Pharmacy (CMOP)
 - Enhanced performance-based incentives
- **Fee for Service, itemization, capitation and global agreements**
- **Recruitment and Retention – does it play a significant impact on revenue operations? (telework)**
- **Internal vs. Outsourcing revenue cycle activities.**
- **Provider Enrollment (Business Office or Medical Staff function)**
- **Debt Management**
- **Staff training/Cross Training**
- **Clearinghouse or other platforms for enhancing revenue.**





CMS I/T/U/ - ABQ Area

Revenue cycle is a continuous process
always be open to other best practices!

Thank you for your time!

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