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Introduction to the Revenue Logic Tool

Background

In August 2014, the Office of Population Affairs (OPA) allocated Title X funds to create the Affordable Care Act Collaborative (Grant Number 1 FPRPA006059). The three primary grantees, namely the Guttmacher Institute, NFPRHA, and Altarum Institute have studied the impact of health system changes resulting from the ACA on Title X centers. The Collaborative has analyzed whether or not service sites continue to see a disproportionate number of uninsured patients, and if so, why. In addition, the Collaborative assessed the long-term factors affecting the sustainability of Title X centers, including costs, billing, and reimbursements. The Collaborative partners also conducted qualitative and quantitative analyses of how state Medicaid and commercial insurance reimbursement policies impact Title X centers, particularly around the issues of billing and confidentiality.

NFPRHA's *Confidential & Covered* project sought to respond to the challenge of confidentiality in the context of a changing health care delivery environment. *Confidential & Covered* created a tool for Title X grantees and subrecipients to estimate unrealized revenue at service sites due to forgoing third-party reimbursement to maintain patient privacy. The tool was designed to be used internally at health centers, though health centers with multiple sites may choose to use the tool across sites or at just one site.

In order to use the tool most effectively, a site must have the ability to: 1) identify visits by patients requesting confidential billing and 2) access the relevant claims information for those visits.

Suggested screening questions for identifying patients with concerns about privacy during the billing process

It is important to establish consistent screening processes that specifically ask about patient insurance status.

Below are screening questions to ask patients at every visit in order to identify visits by insured patients who request that claims not be submitted to insurers due to confidentiality concerns. How and when in the patient flow these screening questions are implemented will vary by site, but potential options include:

- Verbally by a front desk staff during check-in.
- On existing intake forms completed by patients.

QUESTION	RESPONSES

1. Do you have insurance today?	__ Yes __ No
2. Are you using your insurance today? *(If YES to #1)*	__ Yes __ No
3. Why are you not using your insurance today? *(If NO to #2)*	__ Seeking payment privacy __ Cost sharing __ Other

Report Data Elements

Rationale

The Revenue Logic Tool is populated with existing data from health center records. The data elements, listed below, have been selected to include visit-level information about patients and to demonstrate how much revenue the health center could potentially recoup if the claims were submitted to a third-party payer.

Elements described as *optional* reflect data points that could be considered for collection but are not necessary for calculating revenue loss.

A basic overview of the workbook:

- Tab #1: This worksheet contains summary data points for the report period.
- Tab #2: This worksheet contains visit-level data for each visit in which patient indicates a need for payment privacy.
- Tab #3: This tab contains summary calculations based on the data elements entered into Tab #1 and Tab #2.

Limitations

The tool is designed to be used internally at service sites to estimate revenue loss and requires thorough screening and documentation of a patient's need for payment privacy versus confidential services. Revenue loss is difficult to compare across sites due to variations in fee schedules, insurance reimbursement rates, and other funding sources. Due to these variations, there are aspects of the spreadsheet or data elements that may need to be adapted. As a result, there is not necessarily comparable data on revenue loss across health centers.

This is intended to provide a snapshot of revenue loss, with the limitation being that it would not necessarily capture revenue collected toward these services from a patient in the future.

The project leaves it to administrators at individual health centers to determine the impact of unrealized revenue due to the provision of payment that does not breach privacy on their organization.

Data Elements

Below are brief descriptions of the tabs and data field contained in the workbook. It is intended to provide greater explanation of each data field and serve as a reference source as data is entered.

Tab 1: Overview

This worksheet contains summary data points for the report period.

1. **Report Name:** The name the organization will give each report.
2. **Report Period:** The time frame during which the data elements were collected. If using a sample set of data from less than a year, a minimum of three months of data is recommended.
3. **Total Number of Visits:** Total number of visits at the service site(s) that included a Title X-funded service. The purpose is to have a measure of overall family planning visit volume at the health center, regardless of payer source, during the period of data collection.
4. **Total Number of Visits Made by Insured Patients Who Request Not to Use Insurance Due to Concerns about Privacy during the Payment Process:** Of the total number of family planning visits, number of visits by patients with insurance who request not to use it due to concerns about privacy during the payment process. These are the subset of visits for which revenue loss will be calculated.
    - **Total Number of Visits by Insured Patients that Requested Payment Privacy Whose Services You Were Able to Bill Because of Agreements with Insurers** *(Optional)*: The number of visits by patients with concerns around payment privacy for which you were able to bill insurance due to agreements with insurers. Certain states have confidentiality protections at the state level. This could include agreements that suppress the EOB, allow you to use the health center address for all communications, or other such arrangements.
5. **Sliding Fee Scale-Payment Categories:** A label for each pay category on a health center's sliding fee scale should be entered into the template on Tab #1 in cells A10 through A19, replacing the sample labels of Category A through Category J. There are spaces for up to 10 categories, and the sample labels for unused categories can be deleted. The updated labels for your site can then be selected on Tab #2 in column K from the dropdown to ensure consistency.

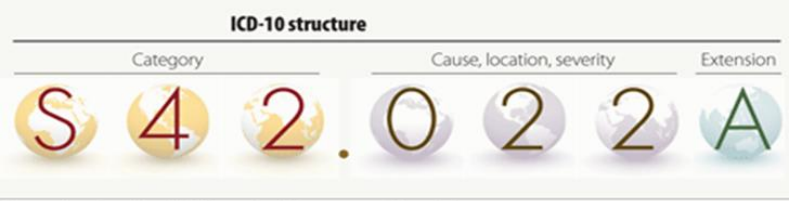
Tab 2: Visit-Level Data

This worksheet contains visit-level data for each visit in which the patient expresses concern privacy during the billing process.

6. **Unique Identifier for Each Visit:** It is important to have a unique identifier assigned to each visit in the worksheet that also corresponds to the health record for that visit. This allows sites to confirm that entries are not duplicative and makes it easy to look up or confirm details about the visit as needed. Suggestions include:
    - **Claim ID** *(Optional)*: Unique claim ID for each visit. The purpose is to have a reference number for each visit, making it easy to look up or confirm details on the claim as needed. Not all systems generate a claim ID if services are not submitted to insurance, therefore this field is optional.
    - **Patient ID** *(Optional)*: Unique patient ID for each visit. If your system does not generate a claim ID, a patient ID and service month could be used for looking up or confirming details about the visit as needed.
    - **Assigned ID** *(Optional)*: Unique visit ID. If a site does not want the visit-level information to be linked to health records, a unique number could be created solely for the purpose of the tool and assigned to each visit listed. For example, the visits could be numbered sequentially. If a site plans to share the data with an external entity, this could be used to protect the data while still providing a unique identifier to each visit.
7. **Service Month:** The month during which the visit occurred. Use the dropdown menu to select from January – December.
8. **Type of Insurance:** Type of insurance the patient had but requested not to use. The purpose is for identifying if clients express concern more frequently about payment privacy with a particular category of payer. This information could be used to inform conversations with health plans or to train staff if needed. Use the dropdown menu to select from:
    - Commercial
    - Medicaid Fee for Service
    - Medicaid Managed Care
    - Other: specify
9. **All Charges (Dollars):** The total value of the services provided (full-fee charges) in dollars during the visit.

10. **All Charges Submitted to Insurance (Dollars):** The total value of services provided, based on full-fee charges submitted by the provider, that are reimbursable by insurance but not submitted to insurance due to confidentiality concerns. If your health center does not submit any claims whatsoever to a patient's third-party payer, regardless of confidentiality needs, those charges should not be included in this column. Examples of services that may not be included, depending on the health center setting and arrangement with payers, are contraceptives dispensed on site, laboratory services run in-house, etc.
11. **Contracted Rate for Services (Dollars):** The total value of services provided, based on contracted reimbursement rates with the insurer, that are reimbursable by insurance but not submitted to insurance due to confidentiality concerns. This value should reflect the contracted dollar amount your health center would receive from the third-party payer if the claim was submitted for Column H.
12. **Sliding Fee Scale:** This is to indicate if the patient received a discount based on the Title X sliding fee scale. It assumes that all patients are assessed for eligibility for the sliding fee scale. Use the dropdown menu to select from:
    - Yes
    - No
13. **Sliding Fee Plan:** Select the pay category the patient was placed in based on the now pre-populated health center's sliding fee scale. In order to utilize this column, a label for each pay category on a site's sliding fee scale must first be entered into the template on Tab #1 in cells A10 through A19, replacing the sample labels of Category A through Category J. There are spaces for up to 10 categories, and the sample labels for unused categories can be deleted. The updated labels for your site can then be selected on Tab #2 in column K from the dropdown to ensure consistency.
14. **Amount Paid (Dollars):** Amount (in dollars) collected from a patient to apply toward the cost of their services. This includes payments based on the sliding fee scale or patient donations. It is recommended to include amount collected on date of service only, not potential for future payments toward the service based on a payment plan.
15. **Calculated Lost Revenue Based on Charges (Dollars):** The total potential revenue a health center loses for the visit in dollars, based on full-fee charges. This is automatically calculated by subtracting the dollar amount in "Amount Paid" (Column L) from "All Charges Submitted to Insurance" (Column H) for each visit.
16. **Calculated Lost Revenue Based on Contracted Rate (Dollars):** The total potential revenue a health center loses for the visit in dollars, based on contracted rate. This is automatically calculated by subtracting the dollar amount in "Amount Paid" (Column L) from "Contracted Rate for Services" (Column I) for each visit.

17. **CPT/HCPCS Code:** The CPT/HCPCS codes for each service utilized during the visit. Including the procedure codes along with the actual charge per procedure or drug provides further clarification and detail to the overall visit charge.
    - **Charge column**: Charges as related to CPT/HCPCS column.
    - **Is service billable to insurance:** For each CPT/HCPCS code, indicate if the service utilized is billable to the patient's insurance, regardless of confidentiality concerns. This will help clarify revenue loss details for visits. Use the dropdown menu to select from:
        - Yes
        - No
            1. **If not billable to insurance, reason**: For services that could not be billed to patient's insurance, regardless of confidentiality needs, the purpose is to provide further detail. Use the dropdown menu to select from:
                - Not contracted with insurer
                - Outside of currently contracted benefits
                - Other
18. **ICD-10 Diagnosis Code**: ICD-10 codes for each visit. ICD-10 codes must be entered in the appropriate structure in accordance with the diagram below.



Source: American Health Information Management Association

The purpose of these data fields is to further understand patterns in visit types for which patients request not to use their insurance due to concerns about payment privacy. This information could also be used in negotiation with plans.

- **ICD-10 Diagnosis Code Description:** The description for the listed ICD-10 code.

19. **Patient Age** *(Optional):* Age of patient.
20. **Patient Sex** *(Optional)*: Sex of patient. Use the dropdown menu to select from:
    - Female
    - Male

- MTF (transitioning Male to Female)
- FTM (transitioning Female to Male)

Tab 3: Summary Calculations

This tab contains summary calculations based on the data elements entered into Tab #1 and Tab #2. The fields are automatically populated based on the information in Tabs #1 and #2 and do not require any user input. It is formatted to be a printable document summarizing some key calculations.

This spreadsheet has been protected to prevent unintentional edits to the formulas. If adaptations need to be made for your organization, unprotect the sheet or contact NFPRHA.

21. **Report Name:** Name of the report (*Reference: Tab #1, Cell D1)*
22. **Report Period:** The time frame during which the data elements were collected. (*Reference: Tab #1, Cell D2)*
23. **Total Number of Visits in Which the Patient Did Not Use Insurance Due to Concerns about Payment Privacy:** The total number of visits during the report period by insured patients who requested services not be billed due to patient privacy concerns. *(Reference: Tab #1, Cell G5)*
24. **Percentage of Total Visits in Which the Patient Did Not Use Insurance Due to Concerns about Payment Privacy:** Of the total number of visits during the report period, the percentage that were visits in which patients chose not to use their insurance due to payment privacy concerns. *(Reference: Tab #1, Cell G5/Cell G4)*
25. **Total Revenue Loss (Based on Charges)**: The total dollar amount of unrealized revenue during the report period from forgoing third-party reimbursement due to patient concerns about payment privacy, based on full-fee charges. *(Reference: Tab #2, Sum of Column M)*
26. **Total Revenue Loss (Based on Contracted Rate)**: The total dollar amount of unrealized revenue during the period from forgoing third-party reimbursement due to patient concerns about payment privacy, based on contracted rate. *(Reference: Tab #2, Sum of Column N)*
27. **Age Group**: Total number of visits in which patients chose not to use their insurance due to payment privacy concerns, by patient age.
    - Minors: Total number of patients under the age of 18. *(Reference: Tab #2, count of cells from column AE < 18)*

- Young Adult: Total number of patients who are age 18 through 26. *(Reference: Tab #2, count of cells from column AE >= 18 and <=26)*
- Adult: Total number of patients who are over the age of 26. *(Reference: Tab #2, count of cells from column AE >26)*

28. **Patient Sex:** Total number of visits in which patients chose not to use their insurance due to payment privacy concerns, by patient sex.
    - Female: Total number of female patients. *(Reference: Tab #2, count of cells from column AF = Female)*
    - Male: Total number of male patients. *(Reference: Tab #2, count of cells from column AF = Male)*
    - MTF: Total number of transitioning male to female patients. *(Reference: Tab #2, count of cells from column AF = MTF)*
    - FTM: Total number of transitioning female to male patients. *(Reference: Tab #2, count of cells from column AF = FTM)*
29. **Insurance Type:** Total number of visits in which patients chose not to use their insurance due to payment privacy concerns, by patient's type of insurance selected from the dropdown options.
    - Commercial: Total number of visits by patients with commercial insurance. *(Reference: Tab #2, count of cells from column E = Commercial)*
    - Medicaid Fee for Service: Total number of visits by patients with Medicaid Fee for Service. *(Reference: Tab #2, count of cells from column E = Medicaid Fee for Service)*
    - Medicaid Managed Care: Total number of visits by patients with Medicaid Managed Care. *(Reference: Tab #2, count of cells from column E = Medicaid Managed Care)*
    - Other: Total number of visits by patients with other insurance type. *(Reference: Tab #2, count of cells from column E = Other)*
30. **Categories of ICD-10 codes:** Count of primary and secondary ICD-10 codes associated with visits on Tab #2. *(Reference: Tab #2, count of cells in column AA and column AC)* Note: The total of all categories will be more than the total visits entered into the tool, as many visits will have more than one diagnosis code entered into the calculation.

Codes have been grouped into general categories as follows:

Category of ICD-10 Codes	Codes Included in the Calculation:
STD Testing (Including HIV)	*Standard Structure*: Z11.3; Z11.4; Z11.8 *Non-standard Structure*: Z113; Z114; Z118

Pregnancy Test	*Standard Structure*: Z32.00; Z32.01; Z32.02 *Non-standard Structure*: Z3200; Z3201; Z3202

Category of ICD-10 Codes (CONTINUED)	Codes Included in the Calculation:
Contraceptive Initiation	*Standard Structure*: Z30.011; Z30.012; Z30.013; Z30.014; Z30.018; Z30.019 *Non-standard Structure*: Z30011; Z30012; Z30013; Z30014; Z30018; Z30019
Contraceptive Management & Surveillance	*Standard Structure*: Z30.40; Z30.41; Z30.42; Z30.430; Z30.431; Z30.432; Z30.433; Z30.49; Z30.8; Z30.9 *Non-standard Structure*: Z3040; Z3041; Z3042; Z30430; Z30431; Z30432; Z30433; Z3049; Z308; Z309
Contraceptive Counseling	*Standard Structure*: Z30.02; Z30.09 *Non-standard Structure*: Z3002; Z3009
Routine Exams	*Standard Structure*: Z01.411; Z01.419; Z00.00; Z00.01; Z00.121; Z00.129 *Non-standard Structure*: Z01411; Z01419; Z0000; Z0001; Z00121; Z00129
Other reasons for visit not listed above	Includes all entries not listed in the above lists.

31. **Sliding Fee Scale Payment Categories:** Total number of visits in which patients chose not to use their insurance due to payment privacy concerns, by payment category on the sliding fee scale. A site's pay categories can be entered into the template on Tab #1 in cells A10 through A19. (See instructions on page 4, #5)

    - [Sample Category]: Total number of visits by patients who were in [Sample Category] on the sliding fee scale. *(Reference: Tab #2, count of cells from column K =* [Sample Category]*)*

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Data Dictionary

Tab 1: Data Element	Cell(s)	Data Element Definition
Report Name	D1	Name of report, determined by the organization.
Report Period	D2	Time frame during which data elements were collected.
Total number of visits made by patients	G4	Total number of visits at the service site(s) that included a Title X service.
Total number of visits made by insured patients who request not to use insurance due to patient concerns about payment privacy	G5	Of the family planning visits in G4, number of visits by patients with insurance who request not to use it due to need for payment privacy. (Visit-level details to be provided on Tab #2)
Total number of visits by insured patients that requested payment privacy whose services you were able to bill because of agreements with insurers	G6	Of confidential visits in G5, number of visits by patients for which you were able to bill insurance due to agreements with insurers. *(Optional)*
Sliding Fee Scale-Payment Categories	A10 through A19	A label for each pay category on a site's sliding fee scale.
Tab 2: Data Elements for visits in G5	**Column**	**Data Element Definition**
Claim ID	A	Unique claim ID for each visit. *(Optional)*
Patient ID	B	Unique patient ID for each visit. *(Optional)*
Assigned ID	C	Unique visit ID *(Optional)*
Service month	D	The month during which the visit occurred.
Type of Insurance	E	Type of insurance the patient had but requested not to use.
Other Insurance Type	F	If type of insurance in Column E is 'Other, specify', a description of other insurance type.
All Charges (Dollars)	G	The total value of the services provided (full-fee charges) in dollars during the visit.

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Tab 2: Data Elements for visits in G5 (CONTINUED)	Column	Data Element Definition
All Charges Submitted to Insurance (Dollars)	H	The total value of services provided, based on full-fee charges submitted by the provider, that are reimbursable by insurance but not submitted to insurance due insurance due to patient concerns around payment privacy.
Contracted Rate for Services (Dollars)	I	The total value of services provided, based on contracted reimbursement rates with the insurer, that are reimbursable by insurance but not submitted to insurance due to patient concerns around payment privacy.
Sliding Fee Scale	J	Indicates if the patient received a discount based on the Title X sliding fee scale.
Sliding Fee Plan	K	Pay category the patient was placed in based on the pre-populated health center's sliding fee scale.
Amount Paid (Dollars)	L	Amount (in dollars) collected from a patient to apply toward the cost of their services.
Calculated Lost Revenue Based On Charges (Dollars)	M	The total potential revenue a health center loses for the visit in dollars, based on full-fee charges.
Calculated Lost Revenue Based On Contracted Rate (Dollars)	N	The total potential revenue a health center loses for the visit in dollars, based on contracted rate.
CPT/HCPCS Code (1)	O	(1) Service utilized CPT/HCPCS code.
CPT/HCPCS Charge (1)	P	(1) Charges as related to CPT/HCPCS code.
Billable to Insurance (1)	Q	(1) Indicates if the service utilized is billable to the patient's insurance.
Reason Not Billable to Insurance (1)	R	(1) Provides a reason service could not be billed to patient's insurance.
CPT/HCPCS Code (2)	S	(2) Service utilized CPT/HCPCS code.
CPT/HCPCS Charge (2)	T	(2) Charges as related to CPT/HCPCS code.
Billable to Insurance (2)	U	(2) Indicates if the service utilized is billable to the patient's insurance.
Reason not billable to insurance (2)	V	(2) Provides a reason service could not be billed to patient's insurance.
CPT/HCPCS Code (3)	W	(3) Service utilized CPT/HCPCS code.

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Tab 2: Data Elements for visits in G5 (CONTINUED)	Column	Data Element Definition
CPT/HCPCS Charge (3)	X	(3) Charges as related to CPT/HCPCS code.
Billable to Insurance (3)	Y	(3) Indicates if the service utilized is billable to the patient's insurance.
Reason Not Billable to Insurance (3)	Z	(3) Provides a reason service could not be billed to patient's insurance.
ICD-10 Diagnosis Code (1)	AA	(1) ICD-10 code for visit
ICD-10 Diagnosis Code (1): Description	AB	(1) ICD-10 code description
ICD-10 Diagnosis Code (2)	AC	(2) ICD-10 code for visit
ICD-10 Diagnosis Code (2): Description	AD	(2) ICD-10 code description
Patient Age	AE	Age of patient
Patient Sex	AF	Sex of Patient

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