

Operational Playbooks

Step-by-Step Guides for Revenue Cycle Scenarios

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1. Playbook: Managing a High-Volume Denial Surge

Trigger: Denial rate increases > 5% week-over-week or a single payer's denial volume spikes > 20%.

Steps:

Step 1: Detect & Quantify

Pull denial trending report segmented by CARC, payer, and service line. Identify if surge is isolated or systemic.

Step 2: Identify Root Cause

Convene denial huddle within 24 hours. Map surge to a specific trigger: payer policy change, system issue, staffing gap, or coding change.

Step 3: Triage & Prioritize

Sort affected accounts by dollar value. Work accounts > \$5K first. Flag accounts approaching timely filing deadlines immediately.

Step 4: Surge Response Team

Temporarily reassign staff from lower-priority work. Consider overtime or vendor augmentation for sustained surges.

Step 5: Payer Escalation

If payer-side error suspected, escalate to payer provider relations representative. Request bulk reprocessing if appropriate.

Step 6: Prevention Update

After resolution, update edit library, training materials, and payer policy documentation to prevent recurrence.

Success Metrics:

- Denial rate returns to baseline within 30 days
- 100% of surge accounts worked within timely filing windows
- Root cause documented and prevention action implemented

2. Playbook: Payer Contract Termination

Trigger: A payer provides notice of contract termination or non-renewal, or the organization elects to terminate.

Steps:

Step 1: Notice & Legal Review

Forward termination notice to legal and contracting immediately. Confirm termination date and any transition-of-care provisions.

Step 2: Patient Notification

Identify affected patients with upcoming appointments. Send required advance notice per state law (typically 30–60 days).

Step 3: AR Runout Plan

Project AR runout timeline. Continue billing under existing contract terms through termination date. Flag accounts for active follow-up.

Step 4: Claim Submission Cutoff

Confirm last date of service eligible for in-network billing. Coordinate with scheduling to redirect or complete care.

Step 5: Staff Communication

Brief front-end and billing staff. Update registration scripts, eligibility workflows, and payer directory.

Step 6: Post-Termination AR

Assign dedicated follow-up team to manage runout AR. Track collections to closure. Escalate unresolved balances to collections or legal as appropriate.

Success Metrics:

- 100% of affected patients notified within required timeframe
- AR runout rate tracked monthly to zero balance
- No claims submitted post-termination date in error

3. Playbook: New Service Line Launch

Trigger: Organization is launching a new clinical service line (e.g., behavioral health, infusion, telehealth).

Steps:

Step 1: Payer Coverage Analysis

Identify all active payers. Research coverage policies, auth requirements, and billing guidelines for new service by payer. Document in a service-line payer matrix.

Step 2: Contract Review

Confirm new service is covered under existing contracts or initiate contract amendment. Load new fee schedules.

Step 3: Coding Setup

Identify all applicable CPT/HCPCS codes. Configure in EHR chargemaster. Validate against payer fee schedules.

Step 4: Auth & Referral Configuration

Build auth triggers in EHR. Create payer-specific auth workflow and tracking tools.

Step 5: Staff Training

Train registration, auth, coding, and billing staff on service-line specific requirements before go-live.

Step 6: Soft Launch & Monitoring

Process first 30 days of claims with enhanced review. Track clean claim rate, denial rate, and auth approval rate weekly.

Success Metrics:

- Clean claim rate > 90% in first 30 days
- Auth denial rate < 10% in first 60 days
- No timely filing denials in first 90 days

4. Playbook: EHR Downtime / System Outage

Trigger: Planned or unplanned EHR or billing system downtime affecting claim submission or AR management.

Steps:

Step 1: Activate Downtime Protocol

Notify all affected departments. Activate paper-based or downtime EHR procedures for clinical documentation.

Step 2: Claim Hold Management

Place claim submission on hold. Document outage start time. Confirm clearinghouse status independently.

Step 3: AR Work Continuity

Redirect billing staff to paper EOB/ERA processing, phone follow-up (if payer portals accessible), and appeal letter preparation.

Step 4: Data Integrity Check

Upon system restoration, run data reconciliation reports. Confirm no claims were lost or duplicated.

Step 5: Catch-Up Submission Plan

Prioritize claim resubmission by timely filing risk. Submit highest-risk accounts first.

Step 6: Document for Timely Filing

Document outage dates for use in timely filing appeals if needed. Most payers accept system outage as extenuating circumstance.

Success Metrics:

- Zero claims lost due to outage
- Timely filing documentation on file for all affected accounts
- AR queue returned to normal within 5 business days of restoration

5. Playbook: Medicare RAC Audit Response

Trigger: Receipt of a RAC (Recovery Audit Contractor) demand letter or Additional Documentation Request (ADR).

Steps:

Step 1: Log & Triage ADR

Log ADR in tracking system immediately. Note response deadline (45 days for ADR; 30 days for overpayment demand). Identify claim(s) and admission type.

Step 2: Medical Record Retrieval

Pull complete medical record for audit period. Ensure all documentation is present and legible.

Step 3: Clinical Review

Have a qualified clinician (CDI specialist, physician advisor, or compliance officer) review record for medical necessity and documentation completeness.

Step 4: Response Preparation

Prepare written response if documentation supports billed services. Include physician attestation if applicable. Submit via certified mail or RAC portal.

Step 5: Appeal if Necessary

If RAC upholds finding, prepare Level 1 redetermination appeal through the MAC within 120 days of demand.

Step 6: Trend & Prevent

Document audit findings. If systemic coding or documentation issues identified, initiate education and process improvement.

Success Metrics:

- 100% of ADRs responded to within deadline
- Overturn rate tracked and reported quarterly
- Systemic issues identified and corrected within 90 days

6. Playbook: Coding Compliance Concern

Trigger: Internal audit, external audit, or tip identifies potential coding compliance issue (upcoding, unbundling, etc.).

Steps:

Step 1: Stop & Assess

Immediately pause billing for the identified code/service if an ongoing concern. Do not submit additional claims until assessment is complete.

Step 2: Engage Compliance

Notify compliance officer. Determine if self-disclosure to payer or OIG is appropriate. Do not ignore or suppress.

Step 3: Conduct Internal Audit

Pull a statistically valid sample of affected claims (minimum 30–50). Conduct independent coding review.

Step 4: Quantify Exposure

Calculate potential overpayment. Determine if voluntary repayment or disclosure is warranted.

Step 5: Corrective Action Plan

Develop CAP: coder retraining, workflow changes, prospective audit schedule, and monitoring plan.

Step 6: Document Everything

Maintain attorney-client privilege where appropriate. Document all steps taken in response to the finding.

Success Metrics:

- Compliance risk assessed within 5 business days of identification
- Corrective action plan in place within 30 days
- Post-correction coding accuracy verified via follow-up audit

