

Managing the Revenue Cycle:
Ten Areas for Improvement



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As we enter the second decade of the 21st century, medical practices face a host of financial challenges. The unknowns of health care reform, changing reimbursement and rising bad debt from the uninsured have introduced a multitude of pressures and uncertainties. Whether your practice aims to maintain physician compensation at desired levels, keep up with overhead expenses or invest in new technologies, the critical factor for success is efficient management of the revenue cycle.

Background

The revenue cycle comprises the numerous tasks of the billing and collection process — namely, gathering and entering data about professional services rendered, and ensuring that bills are paid in full.

Think of the medical practice's revenue cycle as a wheel. The spokes are the critical functions of the billing and collection process. Each function has several key touch points, often in the form of tasks, that practice staff or providers must perform. Unless each function is performed effectively, the wheel will fail to turn. If it stops for too long, the business will collapse. These critical billing and collection functions and their related touch points with providers and staff include:

Contracting with insurers: Managing and monitoring reimbursement agreements with government and private payers.

Eliciting and processing patient information: Scheduling and confirming appointments as well as referrals, registering patients in the practice management system, verifying insurance, obtaining pre-authorizations for treatment, and other tasks.

Capturing charges: Logging all services provided to patients, correctly coding services, providing required documentation and other tasks.

Billing: Producing and submitting claims to payers and sending statements to patients.

Processing payments: Posting payments, handling denials by insurers, and adjudicating accounts.

Handling accounts receivable: Monitoring performance and resolving or appealing payer denials.

Managing collections: Determining and collecting what patients owe, administering financial policies and receiving payments.

For each function and related touch point, a medical practice establishes and assigns the administrative functions that must be performed. Unfortunately, many medical practices do not take firm control over each of these many wheel spokes. Opportunities to interact with patients and payers are missed and, as a result, the revenue cycle does not operate at peak efficiency.

This white paper examines 10 key opportunities where many medical practices can streamline their revenue cycle. In doing so, they will be better able to bring in cash faster and with less effort. You will clearly see the financial outcomes in the bottom line: reduced days outstanding in accounts receivable, lower overhead — and the greatest reward, higher collections.

Each major function in the revenue cycle has responsible parties: physicians, nonphysician providers, nurses and other clinicians; and administrative and billing office staff. Everyone in the practice has a role — often several roles — to play in managing the revenue cycle.

When the wheel of the revenue cycle slows or snags, it may be because responsible parties fail to understand their roles. Other times, a poorly designed function is to blame. Perhaps the practice doesn't provide staff with the tools to carry out the function, or misplaces the task in its work flow.

While dozens of steps can speed up the revenue cycle and avoid missed collections opportunities, here are the 10 most common prospects for improvements. These will, in the long run, produce accurate and compliant billing and ensure that your practice collects what its physicians have earned.

1. Recognize Where the Cycle Starts

The revenue cycle starts as soon as the practice defines the terms of its relationship with an insurer — or the practice's policy regarding patients who have no health care coverage. When the patient makes contact with your practice, the revenue cycle wheel begins to turn. The cycle's beginning includes stating the practice's financial expectations, collecting from patients without insurance and verifying insurance coverage and benefits from those who do.

Medical practices historically viewed their billing offices as wholly separate units from the day-to-day activities of scheduling, registering, arriving and treating patients. This perspective comes from a time when practices routinely waited months for payment after providers rendered medical services. This state of affairs is no longer tenable in today's fast-paced financial world, an environment where medical practices' profit margins have grown ever narrower due to falling reimbursement and rising practice costs. Operating an efficient revenue cycle requires practice wide buy-in to the following principles:

- **Defining** — and knowing — the terms of insurance contracts and establishing an appropriate but strict policy for patients without insurance.
- **Involving** everyone in the practice in the revenue cycle — clinicians, as well as administrative staff — not just the billing office staff.
- **Ensuring** the accuracy of each data element about the patient — demographic, insurance and other information.
- **Recognizing** that the process of getting paid starts before the patient walks in the door.

Promote a broader appreciation of this final point — the process of getting paid starts before the patient walks in the door — by requesting schedulers to describe the practice's payment expectations to patients at the time they make appointments. Require them also to reiterate these expectations in appointment-reminder phone calls. Finally, mandate that time-of-service collection is a core function of front-office staff. Developing a shared vision of where the revenue cycle begins and recognizing that everyone contributes to its success is the first important step toward a successful outcome.

2. Focus on Accuracy

An efficient revenue cycle results in faster throughput, but that does not mean haste. To ensure speed and accuracy, focus attention equally on improving the precision of the data submitted by clinical, administrative and billing office staff.

For physicians, nonphysician providers, nurses and other clinicians. Establish a written policy for timely completion of patient records, full and accurate documentation of all services and recording diagnoses for each visit linked clearly to the services rendered. The policy should also clarify the roles of clinicians regarding waivers and pre-authorization for services.

For administrative staff. Pay careful attention to the order in which assigned tasks are to be performed. What appears to be a logical sequence on paper may not play out in the reality of a busy reception desk. Provide staff the tools and technology to get assigned tasks done. For example, if the practice expects due balances to be collected at the front office, staff need training in how to identify the correct amount, how to ask for it and establish a payment plan if the patient can't pay in full — as well as immediate access to a credit and debit card machine, and the change drawer.

For billing office staff. Clean claims and statements translate directly into faster cash flow. Optimal staffing means having enough employees to allow billers the time to ensure charges are accurate before posting them. Assigning work by insurer allows billing staff to grow familiar with those payers' rules. A practice can prevent many of the denials that hold up cash flow by submitting clean claims that get paid on first submission.

3. Submit Claims Daily

Send claims to payers as soon as they are ready. Use software or clearinghouse services to help identify problems in any denied claims so that corrected claims can be resubmitted as soon as possible. Send billing statements promptly to patients who don't have insurance or who are covered by an insurer with which the practice does not participate.

Don't mail statements only once a week, a protocol that just adds more days to your receivables. By sending statements throughout the week, you spread out telephone calls from patients who have questions about their bills. This bit of forethought allows managers to structure staff in accordance with anticipated work flow.

4. Employ Technology

As insurance deductibles, copayments and out-of-pocket costs continue to rise, a front office employee who knows how to obtain accurate information about patient financial responsibility is a tremendous asset. However, employees' efforts to request time-of-service payments require the support of both information technology and operational design. For example, appointment schedulers should be able to quickly research patient balances and take credit card payments by phone.

Deploy technology appropriately, and don't overlook staff training. A stellar practice management system can't form the basis of an efficient billing office if employees don't know how to use it.

Using technology wisely also includes:

- Verifying patients' insurance coverage, benefits eligibility and financial responsibility automatically before services are rendered.
- Pre-loading protocols based on coding and payer reimbursement guidelines to electronically scrub claims before submission.
- Transmitting claims electronically.
- Automating secondary claims submission.
- Posting payments electronically through electronic remittance and funds transfer, rather than hand-keying.
- Using remote deposit services so payments go into the practice's accounts as soon as possible, not just once a day or, worse, at the end of the week.

Other technology that can improve the billing process includes online bill payment, computerized payment monitoring and automated, credit card-based payment plans.

5. Stay Current

When it comes to billing and collections in health care, rules seem to have been created just to change. Many claims denials and lost billing opportunities occur because medical practices do not set aside a little time each year to track the annual changes made to the CPT®, HCPCS and ICD-9 coding systems. Each annual Medicare fee schedule also brings a host of new rules for covered services and reimbursement.

Medical practices can turn to myriad resources to stay up to date. National specialty societies scrupulously track coding and regulatory changes that affect their members, and most publish newsletters and e-mail alerts about rule changes. To track updates at a local level, tap into state medical societies and professional associations for billers, coders and practice managers. Payers' websites also can provide useful information about changes in payment policies, patient eligibility and other information critical to efficient revenue cycle management.

Practices using paper charge tickets must be sure to revise them each year based on the annual updates by the American Medical Association to CPT codes. An electronic system will accomplish this annual task much more quickly. Because payers make frequent adjustments to fee schedules, and because a practice may deal with dozens of payers, it's worth asking payers for contract clauses requiring the payer to provide at least 60 days' advance notice of any fee schedule change.

6. Leverage Payer Contracts to Improve Billing Performance

To resolve the frustration of an insurer engaging in unfair payment tactics or creating inordinate delays, look to the contract. Shrewd negotiation during contract talks can make the document your ally. Ideally, the contract contains clauses that disallow bad insurer behavior — just as it will prohibit you or your practice from taking certain actions. Contracts with payers deal with many common issues, such as provider enrollment, take-backs and fee schedules. Keep tab on each payer's potential 'hassle factor' by creating a folder for each insurer. Staff can put copies of correspondence, notes and explanations of benefits revealing an underpayment or inappropriate denials into this folder. Retrieve the contents of these "hassle" folders to use at contract renewal to make sure frustrations with the payer are addressed.

7. Involve Patients

Because your medical practice bills the payer on behalf of its patients, it's only natural to ask for the patient's help when something goes wrong in that process. If, for example, a payer denies a claim based on insufficient information from a patient, contact the patient immediately to prompt him or her to respond. (One way to prevent these potential payments problems is to address the issue of information-based denials in the payer contract. For example, seek a contract clause allowing your practice to transfer financial responsibility for the service to the beneficiary — the patient — if the patient does not respond within 30 days to the payer's information request).

Copy patients on any appeal letters sent to payers for services that were rendered to them. Seeing this information will likely stir patients to pick up the phone and call their insurers. Of course, always send statements to patients when bills are their financial responsibility, and hold them accountable for payment.

8. Prioritize

Billing office employees are generally detail-oriented. Therefore, they may lose sight of the big picture and need help prioritizing their work. Abandon alpha-based sorting as the primary work organizer. Instead, encourage staff to work insurance invoices and patient balances in hierarchical order. Set a floor amount for second-level appeals. A \$10 floor, for example, may reflect the cost point at which your practice ends up spending more on the secondary appeal process than the claim would be worth if paid. Use tools to facilitate prioritization, such as creating an electronic calendar with ticklers enabled or, better still, integrate alerts for due dates of tasks or expected responses directly into the practice management system.

9. Follow Through

Whether it's an appeal letter or simply a patient's promise to pay off a balance, make sure to monitor the progress of pending issues. Set up electronic reminders — ticklers — for information requests and appeals. It's the only way you'll guarantee results. Furthermore, follow through when threatening to report a payer to the state insurance commissioner or turn a patient's delinquent account over to the collection agency. Don't bluff.

10. Monitor Payments Closely

Monitor key performance indicators by payer. At a minimum, for each payer, review the days in receivables outstanding, credits, aged trial balance and adjustments by category. Perform quality audits at least once a quarter by reviewing a number of accounts — say, 10 per physician — chosen at random.

Demand that payers provide the allowable amounts for codes your practice's physicians use most frequently. This information allows you to determine whether the insurers are living up to the terms of their contracts. To catch lower-than-contracted reimbursement, set up an automatic query in the practice management system to track each payer's allowables for filed claims. Lower-than-contracted reimbursements are almost always due to the payer bundling charges, down-coding services or making other changes not called for in the contract. Flag every invoice for which the insurer reimburses 100 percent of the charge — that's a sure sign that the practice is charging less than the allowable it is due.

When a claim is paid, the payer reimburses the practice in the form of an allowable amount, often referred to as the "allowance." For each procedure code, the difference between the charge and the allowance is considered a contractual adjustment. The billing office makes this adjustment at the time of payment posting. The adjustment process breaks down when billers treat other types of adjustments as contractual adjustments. These noncontractual adjustments may include claims not paid because the charges were not submitted promptly by your practice, or a payer refusing to remit payment because you were late in submitting the enrollment paperwork for one of your new providers. Be sure billers handle contractual adjustments separately from non-contractual adjustments. Otherwise, what appears to be a glowing 100% collection rate is, in reality, much lower.

Keep these tips in mind as when look for ways to boost your practice's ability to collect the revenue it is due. Collecting revenue is the "revenue" in the revenue cycle.

And remember: Improving management of the revenue cycle starts with staff. To make any of these 10 basic approaches work — or any other approaches, for that matter — you must hire motivated people and give them tools they need to do their jobs to continue that motivation.