Improving Practice Profits Through

Revenue Cycle Management

The traditional billing and collections model is changing. Technology and administrative processes are more complicated. The payer pool grows every day. Reimbursement continues to be a challenge. Keeping pace with these changes takes expertise, time, and resources. Medical professionals spend more money billing and collecting than in any other industry, and even with powerful management software and trained employees, maximizing profit is a challenge. The key to solving this problem is a well-managed revenue cycle.

This guide will give you an overview of Revenue Cycle Management, together with best practices, and considerations for outsourcing your RCM to a third-party provider, or keeping it in-house.

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Contents

Overview of the Healthcare Revenue Cycle

The RCM process consists of four main phases:

Pre-Claim: Entails the creation and management of patient files, contract negotiation, and checking patient enrollment.

Front-End: Everything that occurs before and immediately after an appointment. This includes scheduling and eligibility verification, through to treatment and payment arrangement.

Transaction: Submitting the claim to the insurance provider, and reconciliation payments, either by mail, cash, or electronically.

Back-End: Tracking of both the Patient and Payer, whether co-pay or insurance. This means checking claim status, appeals and resolution, or occasionally transition to collections.

Alongside the RCM process, ongoing tasks like reporting and analysis, compliance, and quality management are continually being executed.

RCM Workfow

The RCM process is complicated, with many tasks and functions that must come together. This schematic provides one way of thinking about the elements of the RCM process.

PRE-CLAIM	Front-End		Transaction		Back-End	
	Pre-Visit	*Visit*	*Claim Submission*	*Inbound Processing*	*Payer*	*Payment*
Fee Schedule and Pricing	Scheduling & Registration	Patient Check-In	Charge Entry	Mail Processing	Claim Status Check	Patient Statements
Contract Negotiation	Eligibility Verification	CO-Pay and Deductible	Claim Scrubbing	Scanning and Indexing	Denials Analysis	Patient Payment Calls
Provider Credentialing	Appointment Reminders	Payment Arrangement	Claim Submission	ERA/EFT Processing	Requests for Information	Conveyance, Small Balance
EDI/ERA Enrollment		Coding and Charge Capture	EDI Management	Payment Posting	Appeals and Resolution	Patient Refunds
		Encounter Documentation	Error Correction	Cash Reconciliation		Transaction to Collections

Month End Closing | **Reporting & Analysis** | **Performance Management** | **Information Technology** | **Compliance** | **Quality Management**

Challenges Facing RCM Today

Every practice is facing a set of core challenges that require a thoughtful approach to overcome.

The old notion of 'billing and collections' is changing and expanding. The revenue cycle process now encompasses almost every aspect of a practice. It is becoming more automated, and is regulated and complex. And the difference between typical and exceptional performance has become necessary for a practice to maintain independence. Practices need to consider:

Maximizing performance: Declining reimbursement and rising costs means practice needs to capture every earned dollar

Minimizing cost: Payment per claim is flat if not declining, and RCM costs are only increasing

Compliance: The American Medical Association estimated that inefficient More complicated than ever, and with higher stakes

Business intelligence: Increasing the need for sophisticated data to drive business

Integration: RCM platforms rely on an expanding ecosystem of technologies that have to function in tandem

Migration to Value-Based Reimbursement: New RCM processes that are different from Fee-For-Service

Direct patient payment: With the increasing costs of health insurance, this is a large source of revenue

Integration: RCM platforms rely on an expanding ecosystem of technologies that have to function in tandem

Staff recruitment and retention: It is harder to find and keep talent (low end salaries get less skilled workers, higher skilled workers are in demand and harder to retain)

It's important to understand that the key to any outsourcing is not just in the technology used, but the people who coordinate and control the software and system. The process is too complicated to be fully automated, but RCM solutions help the staff focus on high value tasks (analysis, rules, denials and appeals, clinic integration, patient pay solutions) while automated services deal with the rest.

Therefore, it is essential for businesses to recognize the value in automating as much of the process as possible – patient registration, eligibility verification, charge capture, claims status reporting, electronic remittance and funds transfer, patient payments, cash management and more. Automation can reduce costly errors, so the staff can focus on improving other aspects of RCM, like collections.

With the help of RCM automation technology, practices can ensure fewer mistakes, precise claims processing, and swift payment recovery. How data for claims is initially collected, how those claims are submitted, and the efficiency of payment, all add up to a profitable medical practice.

Measuring Effectiveness

Every practice is facing a set of core challenges that require a thoughtful approach to overcome.

People

They are the backbone of a well-managed revenue cycle. Healthcare veterans have experience in coding, compliance, electronic data exchange, customer service, billing/ collections, and more, and are the ones capable of managing every aspect of a business.

Process

When followed with strict adherence, the RCM system will guarantee results. The process is made up of data collection, claims submission, AR processing, automation, specialist prioritization, and other steps. Working with information, structure and discipline is what produces reliable higher performance.

Technology

It is used across the entire revenue cycle process. It allows for effective tracking, automation, and interaction, and can be used by a large pool of employees with minimal expertise. It enables every task in the process to be performed quickly, accurately and consistently.

Information

It takes good data to improve any revenue cycle performance. Having access to critical data delivered in simple reports will pinpoint problems and identify opportunities. In today's market, BI is critical to increasing both efficiency and profits.

It's also important, however, to make sure you have the right KPIs in place.

Typical KPIs include:

Payments	Cash is king and the ultimate measure of performance. You'll want to track payments per deposit day, because the number of business days in the month can fluctuate between 18-22, and payments per total provider days worked, to adjust for variations in provider time off.
Revenue Mix	The revenue mix of a practice evolves over time, e.g.: • % From payer v. % from patient • % From office visits v. % from surgeries / procedures v. % from ancillary services • % From physicians v. % from mid-level providers
Net Collection Ratio	Answers the question, 'Are we getting paid what we are contractually entitled to?' Compare Payments to Net Charges (Charges less Contractual Adjustments). Key is a disciplined posting process that distinguishes contractual adjustments from other adjustments.
Visit Volume	Visits are the headwaters of the revenue cycle. • Track trends over a 13-month period (compare to same month last year). • Watch the mix of visit types (new patients, established patients, surgeries/procedures, ancillary services, etc.) to get an early indicator to the future heath of the practice. • Build into the key people (providers, executives, managers) a general understanding of the average payment for each visit type.
RVU's	The most granular measure of work and productivity; tracking RVUs is particularly valuable to compare providers with different specialties. Payment per RVU provides one of the most effective payer-to-payer reimbursement comparisons.
Days in AR	An important measure, but easily distorted (e.g. just writing off denials will reduce days in AR). • Track how 30-day aging buckets resolve over time. • Pay particular attention to the 'old' bucket (varies by specialty - some track 90+ days; some 120+ days)
First Pay Rate	Measures percentage of claims paid in full by the payer on the first EOB (no denial); have to adjust for balances rolled to the patient. Higher the better for faster cash flow, lower cost (working denials costs money), and less likelihood of losing a payment entirely.
Denial Rate	Number of CPTs denied as a percentage of the total CPTs submitted (denials occur at the CPT, not the claim level). While some level of denials is inevitable, a high denial rate (target varies by specialty) indicates where the process (front end demographics, back end coding) in not working as it should. Few things better drive RCM performance improvement than a good denials management process.
Zero Pay %	All claims that receive no payment before they are completely adjusted to a zero balance. Some of these may make sense, but zero pay claims generally mean that work was done for free.

Revenue Cycle Best Practices

Throughout your practice's engagement with a patient, there are a number of ways your can optimize these KPIs at every stage of the revenue cycle.

Pre-Claim	
Fee-Schedule and Pricing	Standardize fee schedule as a common percent of Medicare to allow more consistency in ratio of payments to charges. Balance the need for your fee schedule to be higher than your reimbursement from all payers with the impact of your charges on self-pay/cash-pay patients.
Contract Negotiation	Inventory key terms of all significant commercial payer contracts. Obtain and maintain reimbursement rate for significant payers for top CPT codes.
Provider Credentialing	Use a credentialing management system that provides reporting on the status of the process.
EDI/ERA	Enrollment Select EDI/ERA provider not only on the basis of cost, but also the quality of information and ease of the transaction for data returned to the practice management system.

Front-End – Pre-Visit	
Fee-Schedule and Pricing	Track demographic entry error rate and feedback to staff for process improvement. Communicate expectation for time of service payments.
Contract Negotiation	Fully leverage automated eligibility verification system. Develop process to confirm eligibility for non-verified patients.
Provider Credentialing	Deploy automated appointment reminder system to call patients in advance of their visit.

Front-End – Visit	
Patient Check-In	Capture insurance card and driver's license in practice management system.
Co-Pay and Deductible	Obtain payment for co-pay and any open balance prior to visit.

Payment Arrangement	Obtain credit card and authorization to charge for patient balance due once claim is adjudicated with the payer. Utilize secure 'card on file' system to store and protect credit card information
Coding/Charge Capture	Establish clear policy for timely charge entry; track and report open tickets, by provider.
Encounter Documentation	Establish clear policy for timely closing of charts; track and report open tickets, by provider.

Transaction - Inbound Processing	
Mail Processing	Process mail daily, with clear rules to route types of correspondence to proper person.
Scanning/Indexing	Balance and reconcile ERA transmissions and EFT deposits on a regular basis.
ERA/EFT Processing	Track and report payment posting error rate. Establish clear posting rules so that you can analyze denial information consistently across payers.
Payment Posting	Establish clear policy for timely charge entry; track and report open tickets, by provider.
Cash Reconciliation	Balance and reconcile all payments (bank account with posted payments in practice management system) on a regular basis.

Back-End – Payer	
Claim Status Check	Process mail daily, with clear rules to route types of correspondence to proper person.
Denials Analysis	Capture detailed denial codes/reasons on all denied claims; normalize denial reasons for consistency across payers. Establish regular process to review denial analysis and identify opportunities for improvement.
Requests for Information	Track and report open 'requests for information' (data required for denial appeals) and turnaround time for providing needed information.
Appeals and Resolution	Track 'date on last worked' for open claims in the appeals process. Establish process to regularly review 'zero pay' (write-offs) adjustments.

Back-End – Patient	
Patient Statements	Send statements on a regular and predictable schedule; do not send more than three statements. Begin move to electronic statements (via email) to patients.
Patient Payment Calls	Establish team specifically trained to handle patient payment calls. Establish policy guidelines for patient payment plans that will be accepted.
Conveyance, Small Balance	Automate process of adjusting balance conveyances and small amount write-offs.
Patient Refunds	Establish regular and disciplined process to pay patient refunds due in order to maintain compliance with regulations.
Transition to Collections	Establish collections agency/process/approach in line with the nature of the practice and overall positioning with patients.

RCM Support Functions	
Month-end Closing	Establish and follow a disciplined month-end close process that forces completion of critical tasks.
Reporting and Analysis	Provide a standard and robust monthly reporting package that trends all critical performance metrics. Provide a single page monthly scorecard for each provider. Develop an ad hoc reporting capability to allow for specific and detailed analyses to address particular questions about the RCM process or the practice performance.
Performance Management	Regularly review key RCM process measures to identify gaps in performance and action items for improvement.
Information Technology	Utilize a fully-functional practice management system with an open database for reporting and analytics and an easy ability to integrate third party applications. Integrate with the electronic medical record for demographic and charge data exchange. Provide online payment option through practice website/patient portal. Automate simple and repetitive tasks wherever possible to reduce costs, eliminate errors, and allow staff to focus on higher value work.
Compliance	Establish and maintain a complete compliance plan and a compliance officer for the practice. Conduct regular reviews of provider compliance data (E&M distributions, denial rates, patient write- offs, refunds, use of modifiers, etc.) and billing documentation. Conduct regular provider and staff compliance training.
Quality Management	Conduct regular audits of staff performance and RCM knowledge. Track error rates at key steps in the process.

Should You Outsource Your RCM?

Every practice is facing a set of core challenges that require a thoughtful approach to overcome.

Historically, when RCM was a simpler process led by smaller teams with specialized skills, the primary cost was the workers themselves. Healthcare providers often relied upon individual skills, the perceived 'best' practice was having a strong biller who could find profit within the billing cycle. It made sense to keep this capability in-house.

As businesses scaled and complexity increased, this workflow proved to be flawed. A lack of standardization across employee skill sets led to variations in performance, and profits sitting undiscovered.

Over time, as RCM technology matured, the industry recognized that outsourcing this work helped increase profit across the entire cycle:

- Claims processing shifted from a human activity to a technology enabled process assisted by humans.
- Technology requires capital, which an outsourcer can spread across multiple clients
- Technology requires integration and management, and an outsourcer can hire talent to manage the technology
- Standardized, repeatable processes leveraged by technology can automate profit
- Outsourcer also has scale to invest in business intelligence technology, and talent

There are pros and cons to outsourcing RCM. Some practices will want to retain control of their revenue cycle management in order to avoid "rocking the boat" or to maintain a feeling of self-sufficiency. Some providers may have had bad experiences in the past. But in general, third-party RCM empowers practices to:

Focus on patient care: Eliminate distractions while increasing time spent on healthcare.

Increase revenue recovery: Get rightfully paid for services provided.

Streamline workflow: Increase workplace efficiency.

Increase profitability: Eliminate mistakes that erode revenue and drive up costs.

Make better decisions: Use facts and data as the basis for action.

Reduce risk: Protect from fraud, staff turnover problems, systems downtime, technology obsolescence and other risks

Gain IT flexibility: Invest in a solution that can accommodate future changes and move toward a technology-enabled practice.

Get control: Achieve the financial strength necessary for an independent business. Many outsourcing companies are focused on "conventional outsourcing", like submitting claims, data entry, and collection. But a full RCM solution can involve a range of other activities, including contracting, scheduling, coding, accounts payable, and even payroll processing and physician compensation.

Best Practices for Defining Your RCM Outsourcing Contract

You'll want to make sure that any contract you sign is balanced and fair, with clear expectations of both the practice and outsourcer. Pricing terms should be simple and well defined, and there should be resolution methods for issues that arise, and explicit legal protections for both parties.

It's also important to determine if the contract is clear on defining the services provided by the outsourcer. The pricing should match the scope of the service.

Pricing, of course, should be clear, as should the obligations of the practice. The contract should clearly outline the situations in which the agreement can be terminated, and rights and responsibilities following termination. In general, there are a number of specific contractual obligations both sides will want to ensure:

Outsourcer	Practice
Compliance with applicable laws	Licensed Medical Provider
Timely completion of services	Accurate Representation and Support Documentation
Retention of Necessary Documentation	Timely Processing of Refunds
Notification of Audit, Investigation or	Performance and Participation
Privacy of Personal Health Information	Compliance and Coding
HIPAA Compliant Transactions	Access to Information and Compliance Plan
Data Security	IT Infrastructure
Limitations on Sharing Data with Third Parties	Notification of Audit, Investigation, and Legal Action
Access to Compliance Plan	Control of Unauthorized Access

When beginning contract negotiations with an RCM vendor, the goal for both companies should always be to maximize value. Contracts will always differ in terms of detail and level of specificity, but there are key points within contract negotiations that all companies should monitor, including scope, price, duration, and reporting.