Improving Your Revenue Cycle

Here are some secrets from a professional billing company.

BY
JEFFREY
FREDERICK, DPM

Practice Management Pearls is a regular feature that focuses on practice management issues presented by successful DPMs who are members of the American Academy of Podiatric Practice Management.

The revenue cycle management process is one of the most complex systems in your office. Creating claims, processing claims, submitting claims, and collecting the money that you deserve can be a difficult process. Applying standard principles of professional revenue cycle management can greatly improve your office's success at getting paid.

The revenue cycle management (RCM) process can be broken down into a series of steps. The first step is to assess the process in your office. This involves asking the important question, "Who is involved in the billing process in the office?" The answer, which surprises most doctors, is everyone! All medical team members play an integral part in the successful claim submission and adjudication of all insurance claims. The entire office contributes to the success or failure of the RCM process. It begins at the front desk from the moment a patient calls the office. Capturing the correct demographic information: name address, date of birth, insurance numbers, and everything in-between cannot be over stated. Improperly captured information can lead to rejections, denials, and delay of payment. One third of insurance denials are due to eligibility issues (a highly preventable issue). Who in your office is responsible for eligibility verification? Is your office still calling insurance companies on the phone to check eligibility and deductibles? If so, you need to consider doing what most billing companies are doing, using technology to check eligibility

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through your electronic health records software. It's a simple push of a button that can save many hours of clerical time and unnecessary rejections. This improvement in efficiency could prevent unnecessary denials.

Just to clarify, the RCM process doesn't end with insurance submission. Payment policies and expectations should be conveyed to patients during their first visit or initial phone call. If you are seeing an increase in patient balances, more than likely the cause is a lack of communication. Letting new patients know up front what your financial expectations and policies are can greatly improve your ability to collect co-pays and deductibles. Back and front office team members should be well versed in your offices policies as it relates to patient responsibilities and insurance. Patients often ask medical assistants during a visit about insurance issues. These team members should be given protocols on how to handle these questions so there is an understanding of financial responsibility leading to quicker patient payment. Also, often ignored, but extremely important at keeping patient account receivables under control, is the opportunity during a patient appointment reminder call to review your office payment policies. Identifying outstanding invoices during the reminder call, along with expectations of payment, is highly effective at reducing patient account receivables. Make sure that your office has a policy on this. Proper communication between the billing staff and front office is crucial in capturing this outstanding patient revenue.

Another area that can be attributed to lost revenue is failing to bill for all the services provided. A key area to consider is—are all the charges entered relative to the procedures that were performed? Regular internal billing audits need to be conducted, I recommend at least every six months. This includes examining the appointment list to see if each visit was charted and charges captured. Do chart notes match what services were performed relative to charges captured? To complete the internal audit, a random examination of EOBs should also be performed. Are services being paid appropriately at the correct fees? Do services match the patient's ledgers as reported on the EOBs? Are the write-offs applied correctly and balances transferred to patients? Audits are very time-consuming, but generally can uncover many deep-rooted issues that cost your practice revenue.

When claims are not properly scrubbed, that can also cost you revenue. Scrubbing is a term used to describe reviews of claims for appropriate modifiers, and ICD and CPT coding. Most billing companies will use a scrubbing tool that automatically identifies conflicts and issues before the claim is submitted. This will ensure greater success at getting claims paid on the first submission. The goal here is to get paid the first time. On average, it costs your practice $25[1] each time you need to re-work and redo a claim. The revenue that is lost because of simple avoidable errors adds up quickly. It is in the best interest of each medical office to intimately know the local medical review process (LCD) that governs that region. Rules specific to regions can vary depending on these LCDs. Medicare publishes these rules (LCD) on their regional websites. Contained on these sites are the required documentation, CPT codes, and appropriate linked ICD codes.

Beyond the required basics of coding a claim, capturing the appropriate demographics, and checking eligibility, there is also timely filing and reworking of a claim. There are very strict rules on timely filing for claims. Any delay in this process can cost your practice plenty of lost revenue. Monitoring the time elapsed between the patient encounter, charge entry, submission, claim posting, and patient billing can be very enlightening. Comparing your office's time on these processes against national standards can be a vital asset for your revenue cycle management.

Perhaps the most important part of examining your revenue cycle management process is benchmarking. Asking yourself how your practice compares to national standards and benchmarks is a key metric at truly understanding your practice's revenue cycle management. I believe there are four essential benchmarks that every office should look at.

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The first is "days in A/R". How long does it take to get your average claim paid? This is a very important number to help judge your entire revenue cycle management process. It takes into account all the separate parts of the process. Most practices should fall below 50 days to get a claim paid. If your days in A/R number is greater than 50, then you have a possible bottleneck somewhere in the system. The formula for days in A/R is: (total A/R divided by gross annual charges) x 360. This benchmark should be used as part of the overall assessment picture.

The second important benchmark is the accounts receivable report (A/R). Most billing software will place outstanding revenue in divided time buckets. National benchmarks* that you can measure against are 52% (0–30), 16% (30–60), 7% (60–90) 5.5% (90–120) 17.7% (120+). If your A/R report is not close to these numbers, it is an indication that there is a glitch in the system that may be attributed to poorly worked claims, lack of proper claim modifiers, eligibility errors, or untrained billing staff.

The third and fourth important benchmarks to consider in the rev-

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enue cycle management process are claim rejection rate and denial rates. While both of these identify a claim not paid, their meaning and root causes are different. Claim rejection rates should normally be lower than 4%. These are claims that have been rejected immediately by the clearinghouse on what is termed the front end. It may be because of simple demographic errors, claim data error, missing diagnosis, etc. Claim denials are claims that have been accepted by the clearinghouse (all things in order on the claim) but the insurance company has chosen to deny the claim. Denial rates in general should be below 8%. Denials can be caused by many reasons relative to authorizations, eligibility issues, medical necessity, etc. A very serious issue related to denials is that 50-60% of all denials are never worked to adjudication, basically lost revenue.

If you start to notice a dramatic decrease in revenue (cash crunch), then you're too late! Your billing process is flawed and already broken somewhere. Just requiring your billing department to spend more time on "stuff "will not fix the problems. It is essential that everyone (all staff) in the office understand that they are all connected to the success and failure of the billing process and ultimately the success of the office. Consistent reviewing or implementation of the four cornerstone benchmarks to help identify root cause billing issues can make or break your cash flow. Regular auditing of your billing process will uncover hidden hurdles to increase revenue. Use of technology to increase your revenue cycle management process can also improve efficiency, while decreasing cost and lost revenue. Finally, educating your billing staff is an ongoing process. If your staff is unable to keep up with the pace, consider outsourcing your billing department. Your billing department needs to be the best-trained part of your office. It is important that you collect every penny that you deserve. An office with a poorly constructed revenue cycle management program will make it harder for you to succeed. **PM**

References

[1] MGMA (Medical Group Management Association)

Dr. Frederick is Past President of the American Academy of Podiatric Practice Management, Fellow, and a member of the Board of Trustees. He is National lecturer on coding, billing and revenue cycle management and is Executive Vice President, NEMO-Health™, TRAKnet Professional Billing™, and Past President of the Michigan Podiatric Medical Association.