The Importance of a Revenue Cycle Game Plan

It's all about how your revenue team manages it.

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Spending too much time on administration? You're not alone.

Providers are no strangers to the paperwork associated with medicine. Now, more than ever, it is critical to be efficient by having a well-developed revenue cycle game plan with a competent revenue management team in place. An efficient revenue management system is critical to your practice's financial health and sustainability. Keeping up can be overwhelming, to say the least. Your practice, regardless of size, needs a strategic plan, which will allow you to make informed decisions about what insurance plans to focus on now versus later. You need to set quarterly goals and, based on your practice's strengths, define your tactics for achieving these goals.

The healthcare revenue cycle encompasses all administrative and clinical functions that contribute to the capture, management, and collection of patient services revenue. Submitting clean claims with the correct documentation will result in getting reimbursed more quickly and improving cash flow for your practice. Your team needs to prioritize resources and find a balance between maintaining a high degree of current performance and making sure that they do not neglect old accounts and balances. This challenging juggling act of allocating appropriate time and resources needs to be done daily.

For the revenue cycle division of a practice to be successful, the following components must work together:

- Scheduling and registration;
- Insurance verification, eligibility, and authorization;
- Patient visit and charge capture;
- Billing and claims;
- Denial management;
- Payment posting;
- Accounts receivable follow-up;
- Self-pay payments; and
- Collections.

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However, the cycle traditionally includes three distinct areas that often function separately from each other: front-end; middle; and back-end.

You must foresee upcoming challenges so that they do not obscure your goals and to ensure that you are moving in the right direction, at the right time, and in the right way.

Each component of the revenue cycle includes its own departments, staff, and policies that drive revenue through the cycle. Unfortunately, there tends to be very little coordination among the components. As a result, revenue cycle management staff typically suffers from a lack of understanding of the big picture, including how patient responsibilities are calculated and what is actually needed to process a claim. Your team should have monthly meetings with clinicians, front office staff, and billing team members.

Steps in the Revenue Cycle

The tasks of each segment of the revenue cycle are described in the following sections:

Front-end steps include:

- Patient registration;
- Patient forms;
- Scheduling provider;
- Insurance and eligibility verification;
- Authorization;
- Co-payments and self-pay collections; and
- Payment plans and payment structures.

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Middle steps include:

- Billing and claims;
- Claims edits;
- Charge reconciliation;
- Coding and auditing;
- Provider documentation; and
- Insurance issues.

Finally, back-end steps include:

- Denials;
- Accounts receivable follow-up;
- Self-pay balances;
- Outstanding co-pays;
- Collections;
- Contractual adjustments; and
- Payment posting.

All of these steps require tight coordination among the back-end, middle, and front-end office staff.

A revenue integrity team will maximize operational efficiency, maintain compliance, and guarantee optimal earned reimbursement. The team is built of members of your staff who are familiar with the details of the entire revenue cycle. They collaborate with each other and are the glue that holds the revenue cycle, operations, and financial health of your practice together. Fostering collaboration between front- and back-end staff will make revenue cycle management a smoother process, and patient collections should increase significantly.

How to Create a Revenue Integrity Team Mentality

You have to ask yourself several questions to create a culture that works:

- What are your biggest financial challenges?
- What are your front-end challenges?
- What are your back-end challenges?
- Are you billing all of your charges?
- Do the providers always know what they can and cannot bill?
- Are you addressing these challenges with your staff on a regular basis?

The key is staff training and provider coding education. The training of your staff involves billing requirements and reimbursement updates, operation metrics, and job expectations. Provider coding education includes, at minimum, quarterly meetings and chart reviews.

It is important not only to set yearly goals but also to review them on a quarterly basis. Your practice management system should include productivity and analytical tools that support you in meeting your goals.

Maintaining reconciliation reports will help you stay on target. Developing templates and tip sheets for your billers, coders, and providers will reduce denials, increase operational efficiencies, and enhance the patient experience.

Your billing team must understand the nuances of different payment models, and which ones would be the best match for your practice. They should also educate the clinicians about what it takes to participate in these payment models. Sometimes, you need an outside consultant to advise the practice on a regular basis. All of these skills take training. Going to seminars and listening to webinars are crucial parts of your ongoing training. Identify your staff's short-

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Each Person Must Know His or Her Job Function

Each member of the billing staff must know his or her functions in detail. A sample job description for front-end staff is provided here; however, the list must be customized to individual practices with a focus on their specific specialty.

A front-end staff member has the following responsibilities:

- Greets and registers patients in a prompt and pleasant manner;
- Instructs patients to complete registration, history, and HIPAA acknowledgment forms;
- Requests updates on established patients;
- Collects and enters all insurance referrals;
- Makes copies of patient forms and insurance cards;
- Enters all demographic information and off-bill comments into billing system;
- Calls insurance carriers and patients for follow-up information to complete registration, as needed;
- Is knowledgeable regarding different insurance carriers and plan types;
- Instructs patients about referral and payment processes, as needed;
- Notifies other departments of patient arrival;
- Pulls and files patient encounters;
- Schedules and reschedules appointments for patients;
- Takes messages and responds to requests;
- Performs expeditor and call center duties as needed; and
- Ensures adherence to all HIPAA regulations. PM

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comings and offer corrective action. Senior management should set clear expectation and offer staff any assistance that is needed.

Common Procedure Coding System (HCPCS) codes to patient data and health coverage information, staff must ensure all necessary information is provided on a claim before submitting it to payers.

Providers can improve patient collections by offering electronic payment options through their patient portals.

Clinical Documentation Improvement

Physicians must provide specific information to ensure coders completely capture what services were provided. Coders should not be in the habit of disregarding physician documentation and deciding on their own whether or not a condition should be coded. They have to query; the physician must document.

If an addendum to the code is made two days later, that is acceptable. If it is made 25 days later, it immediately goes into question and holds up the claim. If the initial codes are more specific, it will make it easier to follow the flow without a lot of clinical legwork.

Once providers have completed a patient visit and performed their clinical documentation and coding responsibilities, the revenue cycle continues to the back end, where revenue cycle management staff engages in claims management, medical billing, and final patient financial responsibility collections. After a patient visit, back-end employees perform charge capture responsibilities, translating services and physician time into billable charges.

Healthcare organizations employ a charge master that links clinical codes to a price. Inadequate clinical documentation can result in inaccurate charge capture and resultant revenue leakage. Organizations often employ several staff members to flag charge capture issues and rework the charges. Using a system that trends charge capture data may improve back-end revenue cycle processes.

With billable fees, back-end staff can then create and submit claims to payers. From ICD-10 and Healthcare

Back-end staff also manages claims for a wide range of payers. The wide variety in requirements for different payers can make claim submission a challenge.

Clean claims are ideal, but staff often must scrub submissions to prevent denials. Staff should verify clinical documentation and charge capture accuracy, ensure patient and health information is correct, and check that appropriate codes and modifiers are present.

Inevitably, a share of claims will come back to back-end staff as denials. When that happens, employees should review the denial and attempt to rework the claim to recoup reimbursement. Once a claim has been adjudicated, any remaining balance on a patient account should be sent to collections. Medical billing staff members then create and send bills to patients and also should work with patients to get the full financial responsibility.

Back-end patient collections can pose a major challenge for providers. Providers expect to receive between 50% and 70% of a patient's balance after a visit, but most find that it takes a least a month to receive payments from their patients.

Providers can improve patient collections by offering electronic payment options through their patient portals. Not only will your finances improve, but you will also be ready for any audit coming down the line. Coders and biller must be familiar with the nuances of the following terms and billing concepts:

- E/M services provided during the global period and a clear understanding of modifiers 24, 57, 78, and 79;
- Management services provided during the global period (use of modifier 24, 57, 78, and 79);
- Duplicate claims for E/M services;
- E/M services billed with procedures (modifier 25);
- Documentation to support medical necessity;
- Billing for non-covered services as covered services;
- "Incident-to" services;
- Unbundled procedures; and
- Incorrect place-of-service codes.

Summary: Your Revenue Integrity Team

Your revenue integrity team plays a significant role in your organization. All members should be cross-trained, and should know what tools (e.g., technology, coder application, audit materials) they need to perform their jobs. Your practice should review the plan every six months and tweak it if necessary. An in-depth review of outside forces such as regulatory and compliance is a must. Finally, although you can have a detailed road map, if there is no follow-through you might as well put the plan on your shelf. **PM**

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