Achieving Maximum Reimbursement:

A Physician's Guide to Revenue Cycle Management

By Teri Yates

Teri Yates

PHYSICIANS TYPICALLY hire my consulting firm because they are looking for ways to increase their income. They tell me they need to add new ancillary service revenue streams or negotiate with insurers for higher reimbursement to get there. These are both important strategies, but too often, clients overlook the surest path to increasing income: collecting more revenue for the services they currently offer under existing payer contracts. To optimize income, physicians must understand the fundamentals of how the health-care revenue cycle works and actively manage the people and processes that drive the bottom-line results.

The Difference Between Billing and Revenue Cycle Management

Health-care revenue cycle management (RCM) is the end-to-end process of obtaining payment from insurance companies and patients for medical services. RCM encompasses activities performed by both clinical and administrative staff members, enabled by at least two (often more) distinct software solutions. Some see RCM as a fancy way of saying "medical billing." Still, the activities commonly associated with medical billing (claim submission, payment posting, denials management) do not sufficiently describe all aspects of a comprehensive RCM program.

Most doctors we meet think of RCM first in terms of technology and may have acquired excellent software, believing software alone will yield excellent results. You cannot dispute the value and efficiency innovative technology offers, but in our experience,

there is a vital component driven by the behaviors of people. The reliability of those people to create adequate documentation, resolve exceptions and drive process improvements is of equal, if not greater, importance than the software utilized to submit claims.

Here we offer physicians practical advice on how to increase patient service revenue by highlighting several of the most frequent trouble spots in the health-care revenue cycle. By becoming familiar with the detailed steps that occur, from service delivery to the receipt of payment, physicians can identify what to measure, improve performance and make informed decisions about who to hire for this important function.

Charge Capture

Submitting claims for known billable events is a given, but identifying all billable events is where the opportunities lie: a process known as "charge capture." Charge capture activities focus on the analysis of documentation to look for supplemental CPT codes that may be legitimately billed in addition to those CPT codes initially reported by the provider and, therefore, prevent lost charges. The highest risk areas for lost charges are services provided outside the four walls of a provider's practice location and for services documented outside of a provider's own electronic health record. Lost charge risk areas would include hospital consultations, surgeries performed at a freestanding ambulatory surgery center, or wound-care services provided in a skilled nursing facility.

Clean Claims are Critical

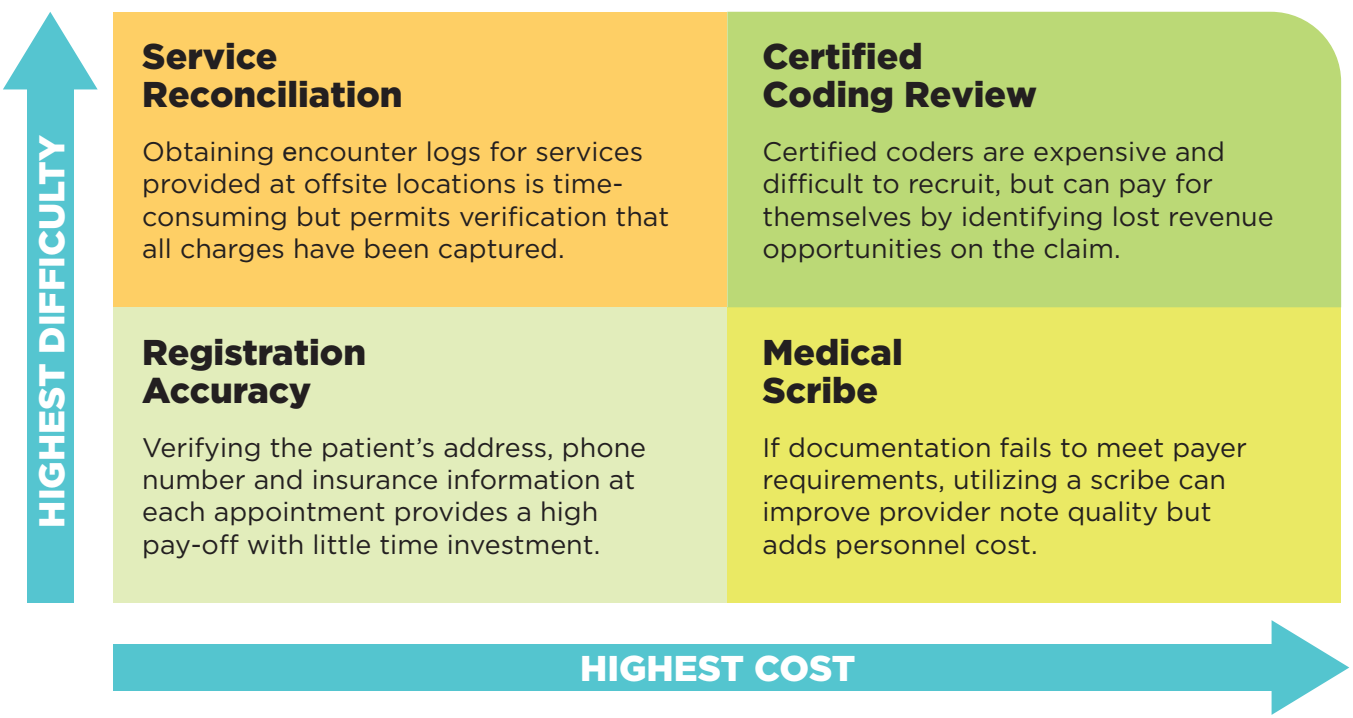
Another distinction between basic medical billing and comprehensive RCM is the dynamic processes to prevent claim rejections and denials. On May 14, 2020, Medscape published its annual physician compensation report, which included data broken down by medical specialty addressing this issue. When asked what percentage of claims are denied or have to be resubmitted, the specialties that commonly offer medical management of cardiovascular diseases—such as internists and cardiologists—reported rejection and denial rates of 15 percent. Surgeons fared even worse; general surgeons reported rejection and denial rates of 19 percent.

A "clean claim" in RCM refers to a claim that is only filed once, contains no errors, and is paid the first time. The data from Med-

Continued on page 66

RCM Improvment Opportunities

Action Steps for Physicians to Improve the Bottom Line



Continued from page 65

scape showed that at best, 13 percent of submitted claims are "dirty." This is significant for several reasons. The immediate effect of a dirty claim is that it slows a practice's cash flow. The length of the delay equals the amount of time it takes to identify the rejection or denial, plus the time it takes the payer to reprocess the claim after it is corrected.

The average cost to work a denied claim is $25, which primarily reflects the personnel time it takes to research and resolves the issue, according to the Medical Group Management Association (MGMA). Each denied claim increases the direct cost to obtain payment, which increases overhead costs for the practice. Even more concerning, experts estimate at least half of all rejected or denied claims are never worked at all. This means a surgeon with an average number of dirty claims is likely losing 9-10 percent of her revenues to ineffective RCM processes.

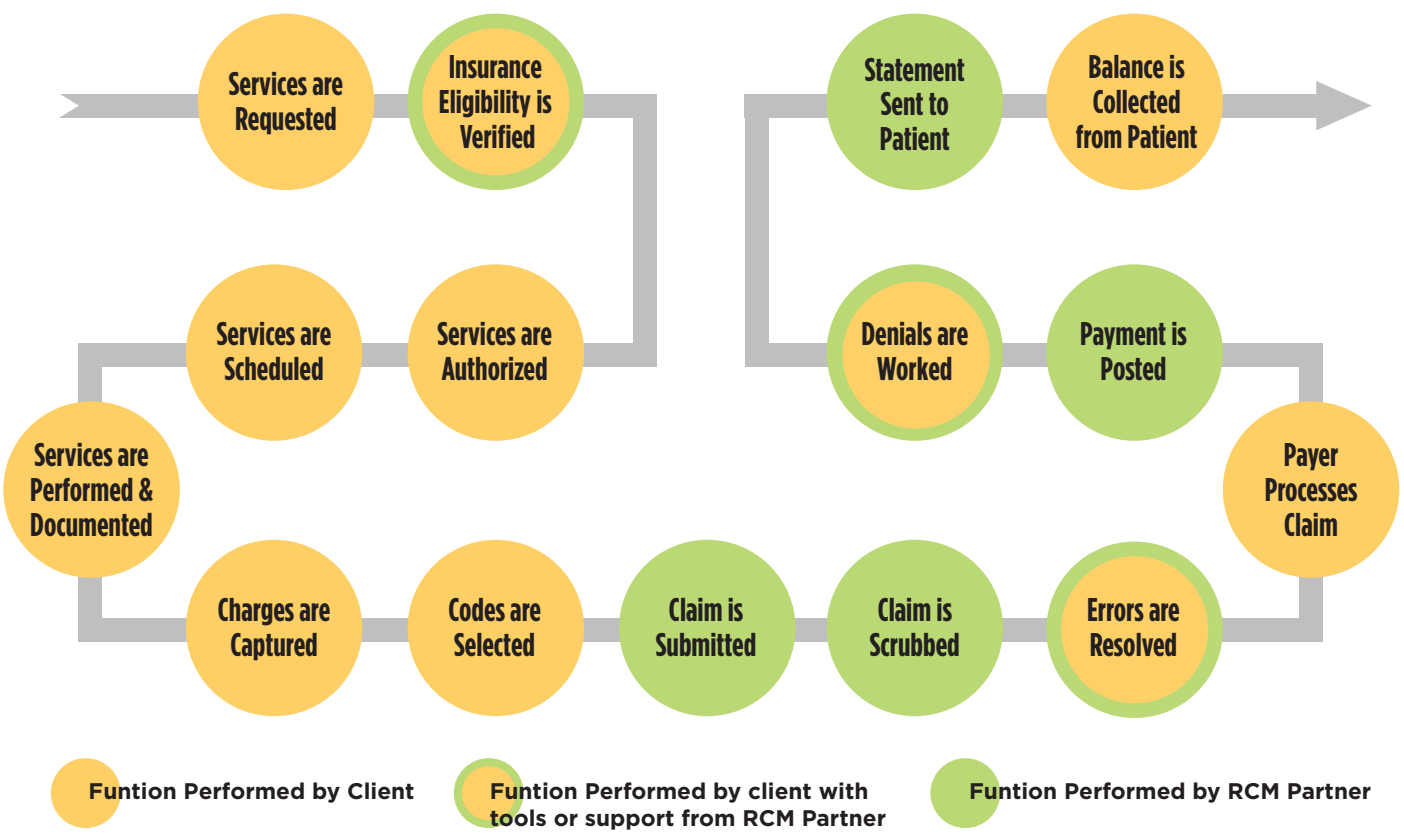
The Technology Trap

Given the significance of these numbers, many billing software companies tout technology as the solution to dirty claims, but technology alone cannot produce clean claims. For example, many billing systems perform automated eligibility checks that flag patients before their appointments if the insurance information listed does not tie out to a valid policy. This can prevent the delivery of service to uninsured patients, but only if the staff member that registers patients reviews and acts upon the flag before checking in the patient for her appointment.

Additionally, a practice is only protected from revenue loss for a time slot if the eligibility problem is identified and meaningful action is taken far enough in advance. If an appointment is flagged, but the matter is not addressed with the patient until she arrives, the appointment slot is left vacant, and the provider still cannot generate any revenue. For the eligibility tool to help the bottom line, office staff must see the flag in advance, contact the patient, and either get corrected insurance information, arrange private payment, or cancel and then re-book the timeslot with an insured patient.

Shared Responsibility RCM Model

RCM Vendor Performs Some Services



Upon initial submission of a claim by the practice, another important type of RCM technology "scrubs" claims, placing them in a holding status for review for a possible error. This is normally deployed at the level of the electronic data interchange (EDI), which is the intermediary that receives claims from the provider's billing system and normalizes the data into the electronic format acceptable by payers. Some billing software vendors incorporate additional scrubbing tools into their own software, flagging and holding possible problem claims before they even cross over to the EDI.

Similar to eligibility, claim scrubbing is not helpful unless the practice assigns people to monitor and work the rejected claims in a timely fashion. That does not happen at least half of the time if the MGMA data stated above is to be believed. Claims left to languish in a rejection queue eventually become worthless because all payers establish a time limit within which the initial claim must be filed.

It is also critical for physicians to focus on the right goals and measure success correctly. Claims scrubbing software provides a metaphorical safety net; the real objective, however, should be to avoid falling off the tightrope in the first place. Rather than continuously correcting the same repetitive rejections, which results in an endless cycle of inefficiency, the revenue cycle team should be empowered and expected to research and correct the root causes through performance-improving activities. Managers can encourage the activities by monitoring and reporting results.

Insourcing versus Outsourcing

Because both people and technology count when it comes to achieving better revenue cycle performance, physicians must evaluate many factors when deciding on the right model for their practices. The possible options include:

- Billing performed in-house by personnel employed by the practice.
- Billing outsourced to a full-service, third-party billing vendor.
- Billing performed under a shared responsibility model, where transactional work is supplied by the software vendor and supplemented by in-house personnel.

The option likely to yield the best results for the lowest investment will depend on the specialty and size of the practice. RCM is easier for practices that generate claims with low complexity because they require less coding support for providers and generate fewer medical necessity denials requiring follow-up. For specialties that primarily bill evaluation and management services, such as primary care, in-house billing may be the most cost-effective option, provided there is adequate management attention to ensure good performance.

It is hard for small and medium-sized practices in specialties with complex claims to achieve good results with in-house billing at a manageable cost. Complex claims need review by highly compensated, certified coders often with advanced training in the physician's specialty. Utilizing these experts ensures money is not left on the table and protects the practice from compliance violations, but it takes several providers to generate enough volume to justify an advanced coding full-time employee (FTE). And even if a specialty coder is hired, the practice cannot cross-train other clerical employees to fill in when that highly specialized individual needs time off or if there is turnover in the position.

"It is hard for small and medium-sized practices in specialties with complex claims to achieve good results with in-house billing at a manageable cost. Complex claims need review by highly compensated, certified coders often with advanced training in the physician's specialty. Utilizing these experts ensures money is not left on the table and protects the practice from compliance violations..."

Unless the practice is large enough to employ several FTEs to support the RCM function, enabling diversification and specialization within the team, outsourcing

Continued on page 68

Continued from page 67

to a reliable, full-service vendor will be most cost-effective for surgeons and other specialists with complex billing.

Shared Responsibility RCM Arrangements

In recent years, practice management and electronic health record software companies have begun offering RCM services as an integral or optional part of their product. These arrangements have the following common features:

- The software and the RCM service are offered as a package on a percent of collections fee, with a minimum monthly rate required by the vendor.
- The vendor leverages automation to increase claim submission speed and consistency.
- The vendor relies upon low-cost labor (typically overseas) to perform transactional work like payment posting.

These arrangements can be appealing to physicians who are daunted by the prospect of managing RCM internally. At first glance, the service seems to come at a very attractive rate compared to full-service, third-party billing. When evaluating these arrangements, it is important to account for the total RCM expense, which includes the vendor's fee plus the cost of the labor that must still be supplied by the practice.

For instance, as part of the service, the RCM partner will send out patient statements and post the payment if the patient sends it by check to a lockbox accessible to the RCM staff. They will also require, however, that all inbound calls from patients with billing questions be answered by the practice. This means the practice must employ someone to research balances disputed by the patient, take credit card payments over the phone and set up payment plans. For specialists, the practice will also need an employee to review and resolve coding-related denials.

To permit accurate forecasting of the total RCM cost, one must obtain a detailed, written delineation of roles and responsibilities from the RCM vendor. If a monthly minimum is required, physicians must also factor in the risk of financial losses if encounter volumes decrease during the term of the contract. Monthly minimums are still enforced if a provider leaves or in circumstances where, for reasons beyond the practice's control, overall revenues are reduced. The most striking recent example of this was the COVID-19 pandemic, when thousands of practices were still required to pay monthly minimums under their RCM contracts despite government mandates to defer elective medical services.

Understanding Your Data to Drive Accountability

No matter what RCM arrangement you select, as a physician, you must frequently analyze your data to identify opportunities for improvement and ensure accountability by those responsible for your practice's revenue stream. Monthly billing system reports generated in a tabular format are not adequate to understand performance, and data should be presented visually in a manner that illustrates trends, variations between providers and revenues associated with specific service lines.

The Health-care Financial Management Association (HFMA) has defined standards for measuring RCM performance through its MAP Initiative. MAP stands for: measure performance, apply evidence-based improvement strategies and PERFORM to the highest standards. When a practice utilizes the standard KPIs defined within HFMA's MAP Initiative, it gains the ability to review RCM performance within a framework that has been validated and widely accepted by health-care finance experts. Results may also be compared to those achieved by similar peers, highlighting areas of opportunity for future improvement. V

Teri Yates *is the President of Accountable Physician Advisors, a healthcare management consulting firm that specializes in developing and optimizing performance in office-based endovascular labs, and Accountable Revenue Cycle Solutions, which provides billing services exclusively to office-based labs and ambulatory surgery centers.*

REFERENCES:

Kane, Leslie. (May 14, 2020) 10th Annual Medscape Physician Compensation Report 2020. Accessed at https://www.medscape.com/slideshow/2020-compensation-overview-6012684#20

Graham, Tina. (Feb. 4, 2014) You might be losing thousands of dollars per month in 'unclean' claims. MGMA Connex. 14(2), 37–38. Accessed at https://www.mgma.com/resources/revenue-cycle/you-might-be-losing-thousands-of-dollars-per-month