HSG

EFFECTIVE REVENUE CYCLE MANAGEMENT IN YOUR NETWORK

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INTRODUCTION

Revenue Cycle Management has become an even more complex issue with declining reimbursements, implementation of Electronic Health Records, evolving local carrier determinations (LCD), and payer credentialing. [The emphasis on healthcare fraud, abuse and compliance has increased the importance of accuracy of data reporting and claims filing.]

The efficiency of a medical practice's billing operations has critical impact on the financial performance. In many cases, patient billings are the primary revenue source that pays staff salaries, provider compensation and overhead operating cost. Inefficiencies or inaccurate billing will contribute to operating losses.

While there are extensive components of the revenue cycle process, we will be exploring the following six key areas related to revenue cycle management:

- Front Office
- Payer Credentialing
- Explanation of Benefits Management
- Audit and Reconciliation
- Patient Statements and Collection Agency Placement
- Dashboard Reports
    - Revenue Cycle Management
    - Charge Lag
    - Provider Productivity
    - Denial Trending

REVENUE CYCLE PROCESS

FRONT OFFICE

The success of effective Revenue Cycle Management in a medical practice is dependent upon a solid foundation. That foundation is based upon the performance of the front office processes. This process starts when the patient or a referring physician calls for an appointment. Well established customer service training is critical in this role. How the patient is treated from this initial contact can set the tone for their experience in the practice.

Key components of the front office's billing process include:

Timely Appointment Scheduling – It is important that the patient's appointment be scheduled in time frame that best meets the patient's needs. A good rule of thumb here is "If it were your loved one, how soon would you want them to be seen?"

Data Gathering and Communication – During the initial phone call all pertinent demographic and insurance information should be captured and entered it into the practice management system. Also, it is imperative to communicate to the patients expectations as to information needed at the time of the office visit such as medications, past medical history, payment of copays or deductible amounts, and arrival time for appointment.

Check-In – When the patient arrives for their appointment it is imperative to obtain a copy of the patient's picture identification and insurance card. The picture identification will reduce the possibility of insurance fraud. Obtaining a copy of the insurance card will ensure you have the most recent insurance coverage information. In addition to obtaining necessary documents the staff should verify all demographic information by either providing the patient with a copy of their registration sheet to verify the information or by verbally reading and updating the information with the patient.

The staff should collect any co-payment or outstanding balances. This is usually the greatest challenge for the front office. People feel uncomfortable asking for money. Consistency in asking for these payments will establish a behavior with the patient and should become an expected occurrence. HSG encourages incentivizing the front office staff for achieving front-end collection goals.

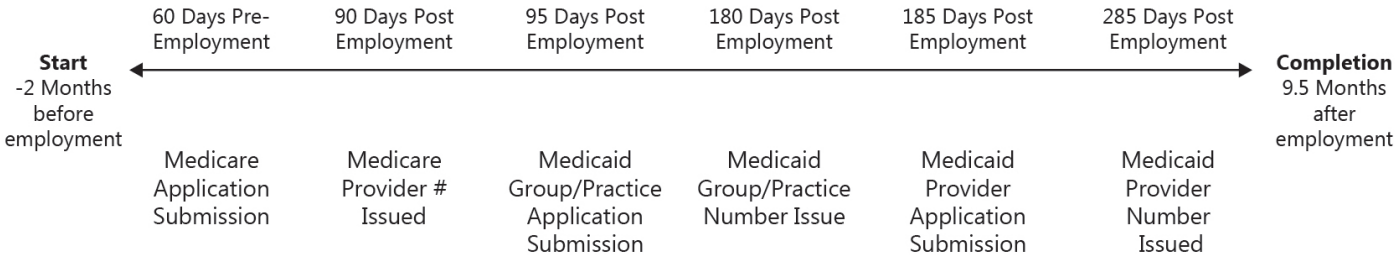
REVENUE CYCLE PROCESS

CONT.

PAYER CREDENTIALING

Health systems and physician practices are facing growing challenges in getting their providers enrolled/ credentialed with insurance carriers. HSG recommends that you allow at least ninety (90) days to complete payer credentialing of new providers. Many health systems are experiencing extended delays in this process due to states' delays in processing state medical license applications and delays by the insurance carriers in completing the enrollment process.

HSG is not exempt to the challenges of payer credentialing. In one employed physician network, that HSG manages, we encountered a unique situation where the state's Medicaid program would not allow us to start a physician's enrollment in the Medicaid program until the physician received their Medicare provider number. This resulted in the physician not receiving their Medicaid provider number until approximately one year after their start of employment. The timeline below outlines this challenge:



This is just one of many examples of the challenges incurred with payer credentialing. Delays in timely enrollment of providers with insurance carriers is catastrophic to the practice's cash flow and growth of patient population.

REVENUE CYCLE PROCESS

CONT.

EXPLANATION OF BENEFITS (EOBS) MANAGEMENT

The development of electronic remittance advices (ERAs) and electronic remittance posting has significantly improved the efficiency of payment and contractual adjustment adjudication. However, it is essential that the staff managing these reports understand the detail of information contained in the EOB. The staff must be knowledgeable of individual carrier reimbursement rates as well as the various denial and/or rejection codes.

HSG recommends that the Medicare, Medicaid, and the top three non-government carriers' allowable amounts be stored in the system, as a reference, to ensure appropriate payment is received. Many practice management systems will reference these amounts and provide an exception report if the payment amount posted is not what was expected from the carrier.

The staff must be familiar with the various denial or rejection codes utilized by the carriers. It is important that the staff can distinguish between a denial/rejection code and an adjustment code.

HSG identified a situation with a client where the electronic remittance posting software was posting denials for missing documentation request as a write off and zeroing the charge instead of posting the transaction as a denial requiring additional follow-up. This error resulted in thousands of dollars of charges being written off before being discovered.

Denials should be monitored by denial type by payer. Denials should be evaluated as to the cause of the denial and what corrective action can be put in place to prevent reoccurring denials in the future. Many reoccurring denials are a result of the actions of the staff when entering demographic and insurance information at the front desk.

Technology should be used to reduce denials for eligibility, pre-authorizations, and referrals. Many practice management systems have the technology to electronically verify eligibility based upon the daily office schedule and insurance plan information on file for the patient. The system will produce a report based on the daily schedule reporting the patient's eligibility, co-payment amount, deductible status as well as referral and prior-authorization requirements.

Timely processing of the EOBs and associated denials can be monitored by utilizing the Aged Trial Balance (ATB) and looking at growth in insurance A/R balances over ninety (90) days old.

AUDIT AND RECONCILIATION

Checks and balances and audit reports are critical to maintaining as accurate A/R as possible. It is important to have a reconciliation process to ensure that all charges, payments and contractual adjustments are captured and posted accurately.

CHARGES

Many practice management/electronic health record systems assign an encounter number when a patient is registered or a charge ticket is generated. Once the charges have been posted, the system will generate a missing encounter report that reflects any encounter numbers that were generated, but have not had charges posted. Services provided outside the office are a bit more challenging. To insure these service are captured the following tools can be utilized:

- Hospital census or daily rounding report
- Surgical cases
  - Internal surgery schedule
  - Hospital surgery schedule
- Nursing home census report

PAYMENTS AND CONTRACTUAL ADJUSTMENTS

All payment posting should be reconciled with the daily deposit and the daily posting journal from the practice management system. As mentioned earlier, various insurance carrier allowable amounts should be stored in the system to insure accuracy of payment. If your practice management system does not have the capability to store insurance carrier allowable amounts, a random audit of the most common carriers payments should be completed on a regular basis to verify reimbursement rates.
Contractual adjustments and write offs should be totaled and reconciled with the daily posting journal to insure accuracy of the posting and to verify that no unauthorized write offs were posted to an account.

CHARGE LAG AND CLAIMS FILING

Charge lag represents the number of days that lapse from the time the service is provided and when the charge is entered into the practice management system. Goals should be established for charge lag based upon the type of service. Examples would include:

- Office Charges – 1-2 days
- Hospital Charges – 3-4 days
- Nursing Home – 2-3 days

If targets are not being achieved, in most cases, it is because the providers are not turning charges in on a regular basis or the staff are not posting charges timely. It is important to have multiple staff cross trained in charge entry. This will minimize delays in posting charges as a result of staff vacation or illness.

Insurance claims should be filed on a daily basis. This should include both paper claims and electronic claims. Daily submission of insurance claims will assist with the cash flow of the practice as well as the work flow at payment posting. Electronic claims filing should be used for as many insurance carriers as possible.

CHARGES

PATIENT STATEMENTS AND COLLECTION AGENCY PLACEMENT

Patient statements should be concise and easily understandable in the information they contain. Patient statements should be processed in cycles throughout the month. The most common practice is to generate patient statements breaking them into four (4) cycles of the alphabet. The following is an example of a 75 day progression of patient billing:

- Initial statement is sent soon after insurance payment is received
- 30 days later second statement is sent
- 15 days later or 45 days following initial statement, collection letter is sent if no payment arrangement is agreed upon
- 30 days later or 75 days following initial statement, the account is referred to a collection agency

Accounts referred to a collection agency should be adjusted off or zeroed out so the A/R balance represents the balance actively being worked by the office staff.

DASHBOARD REPORTS

Dashboard reports are an excellent tool to monitor the performance of the various activities of the practice. Dashboard reports should be used to monitor best practices and should quickly identify if a problem is occurring resulting in declining revenue cycle performance. Dashboard reports should be maintained for each practice as well as a summary for the entire network. It is recommended that monthly meetings takes place with each practice site to include the site manager and the providers to review the dashboard reports. This is an excellent time to discuss opportunities to improve the site's performance. The following are examples various dashboard reports utilized by HSG:

To ensure efficient revenue cycle management, it is imperative that you have dashboard reports that measure performance. Data elements to measure include:

Appointment Wait Times		**Charge Lag Days**
New Patient		
Established Patient		**Denial Rate**
Collection Rates		**Front End Collection Rate**
Net Collection		
Gross Collection		**% of A/R > 90 Days**
Days in A/R		**Credit Balances**

REVENUE CYCLE MANAGEMENT

The revenue cycle management dashboard reflects a rolling 12 months activity. It is recommended that performance targets be established for each category that would represent best practice.

March 2016

Posting Month	Gross Charges	Contractual Adjustments	Gross Payments	Refunds	Gross Collection Rate	Net Collection Rate	Ending AR	Days in AR
Jan-16	1,923,706	(1,045,650)	(918,645)	6,785	47.8%	103.8%	2,363,448	46.11
Feb-16	2,138,564	(1,178,450)	(985,175)	9,865	46.1%	101.6%	2,485,102	48.5
Mar-16	2,175,450	(1,068,420)	(1,054,765)	10,750	48.5%	94.3%	2,864,234	55.8
Quarterly Total	6,237,720	(3,292,520)	(2,958,585)	27,400	47.4%	99.5%		

CHARGE LAG

As charge lag will vary by place of service, it is recommended to report data points by provider by place of service. As stated earlier, it is recommended that targets be established based on place of service.

Practice Name	Provider	Location	Charge Lag
Practice Name	**Doctor #1**	Inpatient	4.00
		Outpatient	4.57
		Office	3.25
	Doctor #2	Inpatient	8.26
		Outpatient	4.37
		Satelite Office	8.08
		Office	1.43

PROVIDER PRODUCTIVITY

The provider productivity report allows each provider in the practice site to see their individual productivity as well as how they compare to their peers. Variances should be explained to determine if a provider was unavailable or if a problem may exist with charge reporting.

	Practice Name								
	Jan-16		Feb-16		Mar-16		YTD		
Rendering Provider	**wRVUs**	**%**	**wRVUs**	**%**	**wRVUs**	**%**	**wRVUs**	**%**	**MGMA wRVU Percentile**
Provider #1	546.16	59%	367.23	39%	757.99	51%	1,671.38	50%	48th
Provider #2	383.11	41%	575.43	61%	716.97	49%	1,675.51	50%	48th
Total 2016	**929.27**	**100%**	**942.65**	**100%**	**1,474.96**	**100%**	**3,346.89**	**100%**	

DENIAL TRENDING

The denial trending report will assist you in identifying denial patterns that may be preventable with modified processes within the practice. It should be noted that most denial trending reports reflect the posting date of the denial and not the month/accounting period in which the error occurred.

Practice Name

Denial Category	Jan-16	Feb-16	Mar-16	YTD Total	
Incorrect Insured ID	$ 1,625.00	$ 1,528.00	$ 1,850.00	$ 5,003.00	19.4%
No Pre-Authorization	$ 978.00	$ 724.00	$ 687.00	$ 2,389.00	9.3%
DOS After COV Term	$ 648.00	$ 426.00	$ 536.00	$ 1,610.00	6.2%
Incorrect POS	$ 1,853.00	$ 965.00	$ 847.00	$ 3,665.00	14.2%
Prov Not Eligible	$ 2,650.00	$ 3,268.00	$ 1,865.00	$ 7,783.00	30.2%
Demographic Error	$ 792.00	$ 648.00	$ 693.00	$ 2,133.00	8.3%
Wrong Diagnosis	$ 346.00	$ 865.00	$ 571.00	$ 1,782.00	6.9%
Beyond Timely Filing	$ 126.00		$ 297.00	$ 423.00	1.6%
No Referral			$ 756.00	$ 1,024.00	4.0%
	$ 9,018.00	$ 8,692.00	$ 8,102.00	$ 25,812.00	100%

Summary

Managing the revenue cycle process is critical to the financial success of your organization. The extent of your ability to monitor revenue cycle functions, identify opportunities and avoid pitfalls is an indicator of your organizations financial health. While this makes sense the execution of effective revenue cycle management is challenging.