HSG

THOUGHT LEADERSHIP

BARRIERS TO PHYSICIAN NETWORK OPTIMIZATION: 5 COMMON REVENUE CYCLE FUNCTION MISSTEPS

BY: DAVIS CREECH & NEAL BARKER

INTRODUCTION

The scope, complexity, and challenges inherent with employed physician networks continue to put increasing financial pressures on hospitals and health systems across the country. As the losses and their resulting pressures continue to mount, it is critical that health systems pay close attention to the revenue cycle function of their physician networks. To minimize these losses, leadership cannot simply rely on increased patient volume or lowering salaries and overhead.

Many clients that ask us to assess the current state of their physician networks are usually lacking dedicated resources in its revenue cycle. Here are 5 common missteps that clients make as they set up these large multispecialty networks.

1 *Not dedicating necessary revenue cycle resources and/or talent to the "physician network"*

Most clients we assist have comingled their physician network billing office with that of the hospital. While that may normally seem like a way to achieve cost savings, in this instance, it often proves the opposite. Ambulatory and inpatient billing obviously have many similarities, but there are just as many differences. Hiring an experienced billing staff with physician billing experience while also staffing that office with the right number and mix of personnel is paramount to maximizing revenue capture and increasing cash flow, which decreases compliance risks. Additionally, effective, physician practice-specific information technology and professional service-specific workflows and policies are also critical to an effective revenue cycle function. We've found that managing the professional revenue cycle in the exact same manner that we manage hospital revenue cycle does not typically work.

2 *Frontend credentialing of providers*

We hear many stories about clients not being reimbursed for services provided by newly recruited/employed/acquired providers, simply because they have not been credentialled by payers appropriately. Often, responsibility for this error falls at the feet of executives negotiating the deal with the new physician or practice. Overpromising and setting unrealistic start date expectations ultimately hurts the organization as not enough time was allowed to properly credential the new provider(s). We suggest allowing at least 120 days in order to begin and complete the credentialing process. This may take even longer if the physician is completing training in a foreign country or they're coming from another state and do not yet have a state medical license. A savvy executive will talk to their revenue cycle personnel before promising start dates and signing LOIs, term sheets, and contracts with state dates. A detailed checklist of items needed for credentialing and someone assigned to manage this process is always recommended. This should include training time with the new providers on use of the billing/practice management and medical record system.

3 *Ignoring or losing sight of current payer contract rates for professional services*

This is often another symptom of a hospital-centric culture in a health system. Our assessments usually reveal multiple issues about payer contracts for professional services. One issue is when an organization does have access to, or knowledge of the rates, those rates have often not been updated in several years. Another more alarming issue appears when management does not know the current payer rates, which consequentially may be significantly lower than the rates the competition in the market is receiving. While many organizations consciously negotiate hospital rates, to the detriment of professional rates, others simply don't know and don't think about their professional rates, which leaves them unwillingly leaving money on the table which commercial payers are more than willing to accept.

4 *EMR optimization around the billing function*

Many HSG clients have transitioned to a different EMR in the past several years. It is imperative that physician billing functions be a part of the transition and EMR build for professional services. Many pitfalls surrounding professional service revenue cycle can be avoided by ensuring the appropriate and correct data for billing is available. For existing EMRs, it is important to know what that data is and how to accurately transition it from one system platform to the other. Finally, during the build, ensure you have the right representation from anyone this affects. Physician and APPs, billers, coders CIOs, front office personnel, office managers and the network should all be at the table during the build out with the vendor

5 *The central billing office is a "black-box"*

We often find those leading a physician network admitting that the revenue cycle function really is a "black box" to them. We are always surprised to find that the physician network operations team does not know the names or roles of the staff in the billing office nor do they receive any periodic management, dashboard reports, or other regular communication from their revenue cycle team. We recommend removing those barriers of communication and actually having a representative of the billing office at your monthly operations meetings with staff and providers. It seems intuitive to us, but deserves stating, operations and revenue cycle teams must work together to solve issues like charge capture, timely coding and documentation, front-end (or time-of-service) collections, registration errors, and decreasing denials. The providers and office staff will be exposed to daily operations, allowing them to have insights which will help the revenue cycle team. Likewise, the revenue cycle team will be able to provide information that will be helpful for the providers and office staff.

CONCLUSION

Some of these initiatives can take time and energy to execute. That said, all positive strides forward require focus and a cultural change. If an organization is unwilling to acknowledge the importance of professional service revenue cycle and the reality that it is different than hospital revenue cycle, then these problems will persist. Additionally, if an organization is unwilling to change its culture as it pertains to the management and operation of physician networks, then once again, these problems will persist. Conversely, an organization with a culture of communication, willingness to change, and the ability to embrace accountability can successfully avoid these pitfalls and missteps. Only then will they be able to cross revenue cycle off the list of challenges they have with their employed physician network. In all aspects of physician networks, HSG strongly advocates for physician engagement, involvement, and leadership. Strong physician leaders can help successfully champion necessary positive changes in your organization.

GETTING STARTED WITH HSG'S APPROACH

HSG has extensive experience with helping health systems establish an optimized revenue cycle strategy. The first step is our comprehensive assessment, which analyzes:

- Fee schedules
- Financial policies and procedures
- Scheduling processes
- Insurance verification
- Patient registration
- Financial counseling
- Coding and charge capture
- Billing and collections
- Accounts receivable management
- Staff knowledge and skills
- Management information systems, and
- Reporting structures

Contact an HSG representative to discuss your assessment

CONTACT THE AUTHORS

M. Davis Creech
Director

O: (502) 814-1183
C: (502) 550-6911
DCreech@HSGadvisors.com

Neal Barker
Partner

O: (502) 814-1189
C: (502) 386-9821
NBarker@HSGadvisors.com