

In a Down Economy, Tightening and Automating Revenue Cycle Processes Can Significantly Improve Group Practice Financial Performance

Focusing on Fundamentals Increases Per-Visit Charges and Speeds Cash Flow

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Abstract:

As the U.S. economy continues to slow, the trend among employers to shift health care costs to employees is likely to accelerate. Many patients may lose coverage altogether. These trends will strain the ability of many medical groups to maintain physician income and adequate cash flow to fund operations. Developing the capability to accurately bill patients at the time of service will help prevent losses. It requires auditing, improving and, where possible, automating basic revenue cycle functions.

I. The Need to Refocus and Improve Revenue Cycle Management Processes

Background – Erosion of employer-sponsored health insurance pressures doctors

In recent years, employers have responded to spiraling health care costs and tightening operating margins by shifting a growing share of health care costs to employees in a variety of ways. While those companies forced to raise employee premium contributions, raise deductibles and co-payments, and cut covered services have primarily been small, companies of all sizes have done so as well.

From 1999 to 2008, the average employee out-of-pocket contribution to health insurance premiums more than doubled to \$3,354 annually, a rate about triple the average wage increase of 34 percent, according to annual studies by the Kaiser Family Foundation and the Health Research and Educational Trust (1). Deductibles also have risen sharply. In 2008, 35 percent of small business employees and 18 percent of all covered employees faced general plan deductibles of \$1,000 or more, up from 12 percent in 2007.

For workers in preferred provider organization plans, the average deductible increased nearly \$100 in 2008 to \$560. Co-payments for many outpatient services also have risen, as have co-payments for prescription drugs, which have increased 10-fold or more for some categories of drugs. Co-insurance is also getting more common, further increasing patient out-of-pocket liabilities.

One of the results of these growing out-of-pocket patient costs has been the steady erosion of the proportion of employees participating in employer-sponsored plans. In 2000, 69 percent of employed individuals and their dependents were covered by employer-sponsored plans, a figure that dropped to 62 percent by 2008. Also squeezed by increased energy and food prices, a growing number of workers, particularly in low wage jobs and smaller firms, simply can no longer afford health insurance coverage.

At the same time employers are squeezing employees for higher coverage contributions, insurance plans are squeezing providers with ever tighter payment rules. An entire industry has sprung up just to help providers keep up with the ever-changing global billing packages, service documentation requirements, pricing indexes, and demographic and other payment compatibility edits imposed through thousands of private and public insurance contracts.

Not surprisingly, the net effect on medical group finances has been largely negative. As the proportion of revenues owed by patients goes up, so do bad debts, and billing and collection costs. At medical groups, bad debt as a portion of self-pay accounts often runs 15 percent or more compared with two percent of overall revenues (2, 3). Patient payment delinquencies are also climbing as a proportion of hospital revenues, according to the Healthcare Financial Management Association (4). At the same time, many groups are losing significant revenue through increased claim denials due to changing payment rules. In some cases insurance contract terms are so complex and opaque that groups have difficulty even figuring out how much they are owed for services, let alone making sure they get paid for them. The twin challenge of collecting more and more of the bill from patients who are often financially distressed while struggling to keep up with rapidly shifting insurance billing requirements have pushed many groups to the brink of financial collapse.

Process audits and automation offer a solution

As noted above, the financial distress medical groups face from rising patient out-of-pocket liabilities and stricter insurance payment practices has not gone unnoticed in the consulting and information technology marketplace. A wide range of products and services are now available that are designed to help medical groups refocus their information gathering and billing practices to maximize both self-pay and insurance collections, and speed cash flow.

Electronic practice management systems are one type of product that can significantly improve medical practice profitability. On the revenue side, automated systems can boost billings by cutting down on missed and under-coded services. They also can speed up collections by billing insurers electronically and enabling accurate calculations of what patients owe, making it possible to collect for deductibles, uncovered services and co-insurance at or before the time of service. On the cost side, such systems can greatly reduce the cost and improve the efficiency of patient billing, particularly if they are integrated with electronic medical record (EMR) systems, accounting systems, insurers on-line eligibility databases and payment systems, e-mail correspondence and even external commercial databases of known insurance claims edits.

Such automated revenue cycle capabilities may sound miraculous to groups drowning in a sea of patient bad debt and denied insurance claims. Indeed, they can make a huge improvement in practice finances. However, automation by itself does not solve the problem. It can only work if the practice's underlying revenue cycle processes – from collecting accurate information to verifying coverage to properly submitting bills to following up on unpaid patient balances and denied claims – are sound. Automating flawed revenue cycle practices will only speed up the rate at which you make mistakes.

The key to refocusing and improving revenue cycle performance is to audit your processes to make sure you are accurately capturing the information you need, and taking the proper steps to process and forward it. Your revenue cycle processes also should include regular performance reviews and integrated process improvement features to keep them up to date. The more revenue cycle processes steps can be automated, the more efficient and effective they will become. However, it is imperative to keep in mind the basics as you move forward with your revenue cycle improvement plan.

II. Steps to Improve Revenue Cycle Performance

Whether automated or manual, the basic steps of revenue cycle remain the same – obtain correct patient information, capture and bill the appropriate charges, collect the payments, follow-up on unpaid balances, and review and monitor performance. Groups seeking to improve performance and refocus on collecting patient liabilities should review each of the following steps.

Step 1 – Pre-Appointment

Getting ahead of the revenue cycle curve requires getting as much accurate information as possible as early in the process as possible. That starts with gathering and verifying patient information before the patient appointment whenever possible. Verifying patient eligibility and coverage before the appointment gives you a better chance to calculate the patient's liability and arrange for payment before or at the time of service. This is especially important because studies show your chances of collecting from the patient drop dramatically after the service is delivered. Collecting at the time of service also reduces the costs of carrying and billing patient accounts, which can be substantial. Practices that do not collect substantial patient information before the appointment generally have more difficulty with both insurance claims denials and patient collections down the road.

Collecting accurate patient information is one of the most important tasks to the process. Staff training in the importance of this patient registration function will pay off in the long run. Monitoring the accuracy of staff data collection will also help you spot and correct performance and system problems.

Prior to scheduling a specific appointment, ask the patient if he or she is a new or established patient, reason for the visit, referral information, insurance coverages, and demographic information (name, address, day-time telephone number, employer, etc.). Explain to the patient the practice financial policies, including the payment of an outstanding balance, and expectations of payment at the time of service.

Prior to the appointment, practice staff should verify the patient's insurance coverage by phone, fax, or on-line services. It is important to know the benefit design relative to the covered services, copay/coinsurance/deductibles, and preapproval requirements.

The pre-appointment phase of revenue cycle management offers many opportunities for automation. Integrating scheduling software with pre-admission processes allows you to automatically generate call lists, and track items needed to register patients and process claims. Many insurers now support practice management systems that automatically verify insurance eligibility, coverage, and deductible liabilities. This is essential information to support time-of-service collections. The less time your staff has to spend obtaining it, the more you save on overhead and the more you are likely to collect from patients and insurers alike.

Step 2 – Appointment

The payoff for much of the work done in the pre-appointment phase comes at the time of the patient appointment. If you've done your homework ahead of time, you will have a very good idea of how much you need to get from the patient. You may already have collected it as part of the pre-appointment process. At the very least, the patient is aware that he/she has an out-of-pocket payment due and will be prepared to pay for it or arrange to do so.

When the patient arrives for the appointment, confirm the patient's demographic and insurance information, copy/scan the driver's license or ID card and insurance card(s). Collect the previously verified copay/coinsurance/deductibles, and request payment for an outstanding balance. If not contained in the patient's chart, ask the patient to complete and sign the practice forms regarding release of information, HIPAA, and financial responsibility.

Effective RCM dictates collection of not only time-of-service payments but also a current outstanding balance while the patient is present in the practice. It is advantageous for the Encounter Form (Charge Ticket) or the electronic practice management system to list the current patient outstanding balance. A variety of payment methods should be available for the patient such as cash, check, credit/debit cards, payment plans, postage-paid envelope, and on-line systems. Staff guidance on the proper techniques to ask for payment will assist in positive public relations with the patient.

Since the Encounter Form (Charge Ticket) provides the basis for billing, it is imperative that the provider utilize a comprehensive and up-to-date Encounter Form (Charge Ticket). This Form should also include the capacity to document out-of-office charges (nursing home, etc.). Capturing these charges on a real-time basis at the time of patient checkout expedites the process and provides the patient an opportunity for payment prior to exiting the practice.

The appointment phase of the revenue cycle also benefits tremendously from automation. Integrating appointment check-in software with patient accounting software enables collection of current and prior balances. Online access to insurance databases helps update eligibility and deductible information. But perhaps the most advantage is to be gained from integrating the practice management system with the EMR. An advantage of an EMR system allows the provider to electronically document and generate charges at the same time during the patient visit. An EMR that captures in real time both consumables, such as vaccines or other drugs administered, and specific aspects of physician practice, such as system reviews and complexity of decision-making, allows you to immediately document the level of service. This permits instantaneous claims processing for insurers that support it, and enables you to bill the patient with 100 percent accuracy for any outstanding balance, effectively reducing your accounts receivable to zero.

It also helps ensure that you don't miss charges or undercode physician services, which are both major sources of revenue loss for many groups.

Step 3 – Post-Appointment

As with the appointment phase of the revenue cycle, the success of the post-appointment, or billing, phase depends heavily on the accuracy and completeness of the patient, insurance and clinical encounter information collected before and at the time of the appointment. Many claims denials are due to errors in patient names, account numbers, birthdates or other personal data. Others result from inadequate service documentation, which also results in undercharging for both professional services and products provided to patients. In addition, many insurance contracts have elaborate rules for what services can be billed together, what services must be bundled, and what services can be billed for specific demographic groups. All of these factors must be addressed to effectively bill services. As with other aspects of revenue cycle management, the efficiency and effectiveness of many post-appointment and billing processes can be automated.

Prior to submission of charges, a pre-billing or coding review assists with the accuracy of information on the Encounter Form regarding CPT and ICD-9 Codes, modifiers, etc. Some available on-line products or electronic practice management systems utilize a scrubber or claims edit for this function.

Electronic claims submission is the preferred method with the fastest turnaround and should be processed daily. Depending on the practice and its billing system, a clearing house may be used. However, there is the opportunity to submit directly to some commercial and federal/state payers. Check edits carefully and correct ASAP. Request that payers notify the practice of routine claim errors (no authorization, incorrect patient demographic or ID numbers, etc.) within 10-13 days of claims submission. It is good documentation to request a confirmation and receipt from payers who directly accept electronic claims. Paper claim submission may be required for secondary and procedural claims.

A standard RCM procedure is the daily deposit of all payments and other funds into the practice bank account. A lock box option offered by some financial institutions may present a viable service for timely deposit. Some insurers support this with electronic fund transfers.

Timely payment posting to insurance and patient accounts is critical to determine the outstanding balances required for follow-up. Payer Explanation of Benefit (EOB) statements are the documents necessary for accurate posting. If possible, the practice should accept payer Electronic Remittance; however, that process should be audited for accuracy and timeliness.

Start Early & Be Proactive are key words in the follow-up of payer and patient outstanding balances. Use practice management/billing reports to pinpoint high/low dollar outstanding amounts, credit balances, unidentified accounts, etc. This is another area in which automated systems are an immense help in identifying problem accounts and creating prioritized work lists for follow up.

Important To Do's are:

Payers

- Access payer on-line applications to review the status of claims.
- Process and work payer denials, rejections, and requests for additional information within 36-48 hours of receipt.
- Audit payer payments received against the rates and amounts expected to be received as outlined in the payer contract.
- Cultivate a relationship with payer representatives to assist in receiving payment.
- Establish regular in-person meetings with top payers.

Patients

- Generate statements according to a schedule—daily for high volume practice, weekly for low volume.
- Ensure statements are understandable—balance forward, open item, insurance balance, patient balance, credit/\$0 balance.
- Provide instructions for payment—credit/debit card, payment plan option, on-line remittance.
- Explain practice's policy regarding dunning messages, final statement, and turning over to a collection agency.

To remain successful, a revenue cycle management program requires monitoring, retrospective and concurrent review. Here again, automated systems can be of enormous value. The practice management/billing system reports supply the information to create a 13-Month Trend Analysis, to benchmark the practice against industry standards, and to build a teaching tool for continued practice education. Likewise, a Dashboard report with summarized information provides opportunities for practice RCM improvement, celebration, and challenge.

III. Conclusion

Many medical groups find they must automate and refocus revenue cycle management processes to keep up with the growing demands of increasing patient liabilities and the burgeoning complexity of insurance contracts and rules. While automation is often essential, it is not enough to ensure satisfactory revenue cycle performance. Automation must be guided by an understanding of the essential underlying nature of revenue cycle processes, implemented to support and continuously monitor accurate information collection, and must be constantly monitored and adjusted to meet changing practice, patient and insurer needs. Practice finances are best served by constantly going back to the basics to keep revenue cycle processes on track.

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