Revenue Cycle Management: Ten Tips to Maximize Revenue
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Introduction

Healthcare is one of few industries where services are not paid for when they are received. Typically, one party (such as a doctor or hospital) provides services to a second party (a patient), but a third party (a health insurance carrier) is often involved in facilitating financial reimbursement for the services provided.

Money keeps the practice in business. Each phase of the revenue cycle is important, from payer contracts to charge capture and collections. Knowing how to manage the revenue cycle not only ensures the financial viability of the practice, but also minimizes the time and effort spent collecting payment for services rendered.

The purpose of this paper is to gain a better understanding of what you can do to efficiently manage the revenue cycle and how to maximize potential revenue.

1: Review payer contracts

Payer contracts often contain complex reimbursement language and formulas that can be difficult to monitor and manage. It is important to know what you are agreeing to when you sign any contract, but especially when it comes to payer contracts. Be sure you know and understand the expected reimbursement and contractual allowances before you sign. Contract negotiations can be difficult, especially if you are a solo practitioner. You have limited power to negotiate unless your specialty is in high demand and there are limited providers available in your geographic area. When negotiating, be sure to optimize trade-offs and to understand the total value of the agreement prior to contract execution. It could be beneficial to take less reimbursement on office visits if you can get more money on high dollar surgical procedures, but make sure you evaluate this against your current or expected volumes.

2: Know the Law

Under the Indiana “Prompt Pay” law, payers must pay or deny a clean claim within 30 days of receipt if filed electronically and within 45 days of receipt if filed on paper. While the definition of a clean claim could be disputed, no response from a payer within the 30 to 45 day window should result in immediate follow up. Medicare reimbursements are dispersed within 14 days of electronic claim submission, so inquiry on those unpaid claims should occur within 15 to 20 days.

Most practice management systems will allow batching of unpaid claims by insurance type so that inquiry can be made on multiple claims with one phone call or internet inquiry. Pending claims should be worked on a daily basis, beginning with accounts with the highest balance and oldest age first, such that every unpaid account is reviewed at least once every 30 days.
3: Clean claims = fewer denials

A serious concern in healthcare reimbursement today is decreased or delayed reimbursement due to claim denials. The challenge is how to quickly identify the source of the denials and fix the problems. Education is the key to clean claims. Providers, front desk, billers and clinical staff all contribute to the information that is submitted on a claim. Each individual needs to understand how their role impacts claim payment. When denials are received, they should be identified with a reason code and posted in the practice management system so a denial report can be generated at month-end. This gives managers a clear picture of where further education is needed.

4: Respond promptly to claim denials

After receiving a claim denial it is important to correct the claim and rebill it to the insurance carrier promptly. Claims often go unpaid and bump up against timely filing limits when the biller keeps a “zero pay folder” to work in the future. Denied claims should be addressed daily as they are received.

Each insurance carrier handles resubmitted claims differently so it is important to know what each carrier expects. With some carriers, if the claim is simply rebilled electronically with no notation, the claim will be denied as a duplicate. Some carriers will allow the provider’s office to fax a corrected claim directly to their claims processing department. Others require that the claim be resubmitted either electronically or on paper. National Government Services, Indiana’s Medicare carrier, allows for certain items to be corrected with a telephone appeal.

5. Review Payments Carefully

Payers will often make mistakes when processing claims that need to be appealed for proper reimbursement. The person posting payments must pay attention and question anything that does not look right. Some things to watch for include:

- dropped or missed procedures
- one procedure bundled into another and paid based on one code instead of two
- modifiers dropped that justify bundled procedures
- multiple units ignored
- payment based on the wrong fee schedule

The best practice management systems have the ability to load payer fee schedules so you know when payments are posted whether they were paid correctly or not.

6: Appeal claims paid in error

Any services paid incorrectly should be appealed. Sometimes errors can be addressed over the phone, but often they require a formal appeal letter. It is important when
appealing claims that a cover letter be submitted explaining why the claim is being appealed. The cover letter also notifies the carrier of any attached documentation accompanying the claim. Further documentation may include progress notes, lab or other test results, operative notes, fee schedules, copies of CPT guidelines or Medicare policies to support the appeal. Keep copies of all appeals and the results for reference with future appeals.

7: Don’t get frustrated, get help!

Practices should not hesitate to contact the State Insurance Commissioner if they feel they are getting the run-around from a particular payer after reasonable attempts to collect. The Department of Insurance assists providers in resolving insurance problems with companies licensed in Indiana. Contact the Insurance Commissioner at:

Indiana Department of Insurance, 311 W Washington St, Indianapolis, IN 46204
(317) 232-2395 or (800) 622-4461 or http://in.gov/idoi/

The Department of Insurance may be called with general questions, but in order for them to investigate a disputed claim they must have written documentation with as many details as possible. The IDOI complaint form can be found at http:www.in.gov/idoi/files/complaint_form.pdf. Documentation should include a copy of the insurance card, the claim form, and documentation reflecting all efforts to resolve the claim, as well as responses from the payer. A separate complaint should be filed for each patient involved. Most insurance companies respond quickly when the State Insurance Commissioner becomes involved.

(Note: Complaints regarding Worker’s Compensation claims should be sent to the Worker’s Compensation Board, 402 West Washington Street, Room W196, Indianapolis, IN 46204.)

8: Patient balances

Sometimes asking patients for payment puts the office staff in an uncomfortable position, especially when the patient becomes disgruntled. However, most insurance companies require that the patient’s co-pay be collected at the time service is rendered. Staff members working at check-in and check-out should be comfortable asking for payment. Often providing a script requesting payment helps staff members to be more comfortable and consistent with requesting payments. Contracted providers are obligated to collect the co-pay at the time of service. Failure to do so could be a breach of contract.

The most important thing an office can do is to develop an office financial policy with regard to patient payments. Developing an office policy is important to ensure that all patients will be treated the same with regards to financial payment. A financial policy makes the patient aware of their responsibilities with regards to payment for services.
Outline in your policy the exact process which will be followed should the patient refuse to pay on their account.

Attempts to collect outstanding balances should be made each time the patient is seen. The cost of pursuing payment after the patient leaves only decreases the value of the dollar collected. The more time that passes the less valuable the dollar becomes and the more difficult it is to collect. Patients know whether you are an office that expects payment or one that will extend free credit. The most successful practices use one or more of these techniques:

- Notify patients when scheduling and confirming appointments that they should 1) bring insurance cards and photo ID to each visit; and 2) come prepared to pay copays and outstanding balances at the time of service. Let them know up front what credit cards you accept.
- Collect copays and outstanding balances at check-in rather than check-out. Staff should be direct without being rude when asking for money. Confidently stating “Your copay is $35. Will you be paying with cash, check or credit card?” is better than asking “You have a balance of $132. Would you like to make a payment today or should we bill you?” Why pay today if you don’t have to? Your office is not a bank and should not routinely extend credit.
- Start payment plans at a maximum of three to six months and a minimum of $25. It costs money to send statements and process multiple payments. Offer discounts if the balance is paid in full to get the account settled quickly.
- Don’t spend money on statements to collect $5 and $10 balances. Collect small balances the next time the patient is in the office.

9: Hire and retain the best employees

Generating revenue is the most important task in the financial success of the medical office. The people hired for these roles should be seen as an investment. Ongoing training is critical to their success as the rules and regulations are constantly changing. The cost of one seminar could easily be recouped in a couple of correctly billed surgeries. Incorrect claims or missed charges could be costing you millions. Invest in your billers and do everything you can to retain the best employees. Workers who feel valued will usually deliver exceptional results.

10: Monitor benchmarks and key performance indicators

Benchmarks and key performance indicators should be reviewed monthly. Let your billers know what is expected so they can monitor and achieve the goals. Analyze trends on a monthly basis and identify any warning signs before they become serious. The following benchmarks may be used as a baseline, but each specialty and/or practice may want to adjust these:
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- Average number of days revenue in A/R at a maximum of 45 days
- A/R greater than 90 days less than 20% of total A/R
- Credit balances less than 4% of total A/R
- Bad debt write-off less than 2% of total charges
- Net collection percentage 96% or greater

There are many other things you can review monthly that will help you monitor financial performance, including:

- Procedure analysis compared to CMS Norms
- Ratio of charges to payments and adjustments
- Drop in reimbursement by individual payers

Conclusion

We are living in difficult times that require offices to do everything they can to keep the practice in business. Every employee is valuable and should take responsibility for their role in the practice thus helping the revenue cycle to be clean and efficient. This document has shown not only how to manage the revenue cycle and ensure the financial viability of the practice, but also minimize the time and effort spent collecting payment for services rendered.