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Original Research

Revising a media plan in revenue cycle management: A review & data base research

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ABSTRACT:

Background: Revenue cycle management all clinical and administrative activities related to generating and collecting patient revenue has gained in importance in today's business environment in which hospitals are confronted with stricter regulations and billing requirements, underpayments, and greater delays in payments. **Objectives:** To despite the continued interest of practitioners, revenue cycle management has not received much attention in health care finance research. With the widening gap between overhead expenses and reimbursement, management of the revenue cycle is a critical part of a successful vascular surgery practice. **Methods:** It is important to review the data on all the components of the revenue cycle: payer contracting. Appointment schedule with the patients, preregistration, registration process, coding and capturing charges, proper billing of patients and insurers, follow-up of accounts receivable, and finally using appropriate benchmarking. The industry benchmarks used should be those of peers in identical groups. Warning signs of poor performance are discussed enabling the practice to formulate a performance improvement plan. **Results:** Most benchmarks are based on Medical Group Management Association 2007 data based on the 2008 report percentage of patient excess was 96%-98% the average billing percentage in <7 days Month's revenue in accounts receivable The goss collection ratio the median was 41.6% and Net collection ratio median 94%. Accounts receivable/ collection Posting of cash and contractual allowance <24 Average collection period or days in patients the median 47.1 days Accounts receivables median was 22.3%. For expenses overheated percentage of cost to collect bad debt expense was <5%. **Discussion:** The above outline was not intended to detail every aspect of the revenue cycle, but to be a reminder that a common sense, orderly and consistent approach to producing financial stability is not an option. With overhead expenses climbing and margins narrowing, even a 1% or 2% improvement in collections could make a big difference to your bottom-line. **Conclusions:** As an owner of your practice, you are undoubtedly familiar with some parts of the general process of the revenue cycle. But, since the survival of the practice depends on the most efficient and accurate process, additional time spent on learning about the details of the financial report and how your practice compares with benchmarks is worth the extra effort.

Keywords: Medical coding, Medical Billing, Revenue cycle management.

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INTRODUCTION

Despite a recent slowdown, the growth in hospital spending continues to outpace the growth in the resources available to pay for it. Over the past two decades, hospital expenditures have increased by an average of seven percent per year reaching $718.4 billion, or $2,360 per person, in 2008 (1) As a result, there is tremendous pressure on key industry stakeholders to mitigate further growth in hospital spending (2). Government health care programs, such as Medicare and Medicaid, have responded to these pressures by mandating lower increases in hospital reimbursement rates. Consequently, Medicare and Medicaid now frequently pay hospitals less than what it costs to treat their beneficiaries resulting in payment shortfalls for hospitals (3). Hospitals also feel significant pressures to contain health care costs from private health insurers and large employers, which use their market power to squeeze payment and create bureaucratic hassles for health care providers (2) Historically, hospitals have mainly focused on cost management to deal with these pressures (4). Cost

containment efforts alone, however, may not be sufficient in the complex revenue cycle management environment that hospital managers are facing today. Considerable changes in hospital reimbursement including the introduction of Medicare's Prospective Payment System in the 1980s, the formation of managed care organizations in the 1990s, and the growth in consumer driven health plans in the 2000s have intensified the need for hospitals to maintain and stabilize revenue streams and improve collection efforts (2,4). In today's business environment, cost management has thus diminished as a single predictor of hospitals' financial performance while revenue cycle management has gained in importance. In today's business environment, cost management has thus diminished as a single predictor of hospitals' financial performance while revenue cycle management has gained in importance. Hospital revenue cycle management includes all clinical and administrative functions related to the generation, management, and collection of patient care revenue. Although historically focused on back end tasks, such as billing and collections, in recent years hospital financial managers have directed more of their attention to the front end of the revenue cycle including patient scheduling and registration, insurance verification, and preauthorization as well as the core tasks of the revenue cycle including medical documentation and coding (5,6). Up-to-date, well operated practices at the front end of the revenue cycle allow hospitals to improve their performance at back end tasks and thus generate greater amounts of patient revenue and collect it in a timely fashion (7). Advances in technology, for instance, allow patients to schedule appointments and complete online registration information conveniently over the internet. Likewise, integrating core tasks, such as the documentation of patient care and medical coding, into the revenue cycle has become paramount to insuring appropriate billing and claims collection at the back end. Specialized coding software, for instance, allows hospitals to substantially improve the accuracy of medical coding, which will become even more important once the currently used ICD-9 codes are replaced by more detailed and complex ICD-10 codes. The importance many hospital financial managers currently attribute to effective revenue cycle management is also reflected in their hiring of external management consultants. Hospitals' need to maintain and stabilize revenue streams and improve collections has thus sparked the creation of a new industry of consultancies that specialize in helping their clients improve their performance at managing the revenue cycle. Examples include Accretive Health, McKesson, and Stock amp, to name but a few of the players in this new and growing industry.

METHODOLOGY

COMPONENTS OF THE REVENUE CYCLE

The revenue cycle consists of the following major components. At each step it is important to not only complete or obtain the required information, but also to review the previous steps to insure that the information gathered thus far is accurate and complete.

Payer contracting: A contract that provides little volume and low reimbursement serves little purpose vs. a medium range reimbursement agreement with higher patient volumes.Evaluation of the potential patient load, reimbursement allowances, administrative requirements, and contract terms must be performed. Always be alert to the contract terms, not just the reimbursement schedule. The administrative burdens could be so onerous as to make collections difficult and time consuming. Read the entire contract Get help interpreting it if you do not understand specific language. The contract was written by the payer and for the payer and few, if any, changes will be permitted, so be extra cautious. Contracts should also be reviewed every year. A "tickler" file must be set up as a reminder of the contracts coming up for renewal and review. This is especially true of "evergreen" contracts that renew automatically on an annual basis unless one of the parties proposes changes.Payer credentialing usually can not begin until the privileges are approved and can take from 6 to 9 months to complete with no guarantee of back dating the effective date. Challenge Credentialing by hospitals and payers are two entirely different processes. Some payers drag this process out which results in the physician seeing patients before he/she is an accepted provider. This can result in a significant number of rejections and nonpayment because the physician was not credentialed on the date of service. Determining eligibility is difficult because patients switch plans frequently and do not remember to notify the practice. Phone calls to verify coverage are time consuming. Swipe card terminals to verify eligibility are now available for some insurance companies. Many of the larger payers offer web based on-line access to their enrollment files for participating providers. Most state Medicaid plans do the same. These resources are faster and more reliable than the phone and there is no cost. We can also check for prior balances that are still due and arrange for payment along with any current deductibles and coinsurance that may be due for the scheduled visit. A few insurers such as United Healthcare offer "real-time claims adjudication" enabling your office to collect any out-of pocket payments from the patient before checking out. Reminding the patient to bring insurance cards is also required.

Appointment scheduling: Although this encounter with the new or established patient is for the purpose of scheduling the appointment, there is a great deal more being set into motion. Once scheduled, the preregistration and registration functions described

below are scheduled as well. These two steps will play a major part in achieving our goal of increased collections. Whether Medicare or another payer, an advance beneficiary notice (ABN) should be prepared and signed by the patient acknowledging that they understand that they may be responsible for payment in full for the services to be performed. The scheduling system can also provide a great deal of valuable information to the practice. Even a fairly basic scheduling system can provide much data that can help a practice get a good view of its patient population. Information such as age, sex, zip code sorts, referring physicians, and no show rates can assist the practice in tailoring its functions to the patient needs. The system should also include an automated appointment reminder function and perhaps even allow our more computer minded patients to schedule their own visits. Preregistration This advance contact with the patient saves time by establishing a file for new patients and updating and verifying information on established patients. Patients move, change jobs, enroll in different insurance plans, marry, and change names. Whether done by phone or mail, this step provides an unhurried opportunity to make sure everything we believe to be true about the patient is up to date and accurate. Online registration is becoming more user friendly and can simultaneously validate the patient's address with the US postal service, confirm an existing patient JOURNAL OF VASCULAR SURGERY Volume 50, Number 5 Manley and Satiani 1233 record, verify eligibility with the insurer, and transfer appropriate information to the billing part of the system. The preregistration period also allows time to verify insurance coverage and to confirm that the anticipated services will be eligible for payment.

Registration: If the above preregistration has been handled properly, there should only be a few things to complete upon the patient's arrival for their appointment: A brief review of the demographic and financial information, obtain any required signatures, copy insurance cards, and collect any past due and/or current balances.

Registration If the above preregistration has been handled properly, there should only be a few things to complete upon the patient's arrival for their appointment: A brief review of the demographic and financial information, obtain any required signatures, copy insurance cards, and collect any past due and/or current balances.

Charge capture/coding: As third party payer fee schedules continue a downward spiral and we face the pressures of an economy that is damaging our ability to collect what is due, it becomes even more important to identify and charge for every legitimate service provided to our patients. Whether the billing system used in the practice is completely manual or highly automated, the services must be able to be identified for billing. This may take the form of a simple billing sheet or the most modern hand held device that assists in coding, verifying that documentation is adequate and insuring that all services are captured for billing. Real-time input of charges into hand held devices may significantly decrease the number of first-pass edits prior to being sent to payers. However, the down side to most current devices is that there is little scope for alteration or notations unless comments are entered into a separate field for billing staff. Missing even one office visit or procedure a day can cost many dollars over time. Whether our physician's code or we use chart abstractors or coding specialists, we must provide the tools to complete the job. Making sure our coders are certified, have access to current journals and publications, and attend learning events represents a good investment for the practice. In addition, they need the most current coding books or software programs to properly code the services. This is critical for a multitude of reasons including getting the correct payment for the service provided, getting paid promptly and eliminating delays in payment. A side benefit is the avoidance of a third party payer audit that could result in substantial paybacks for incorrect or improper billing. Many practices do not regularly review and raise their rates and as a result, could be leaving money on the table. Inaccurate coding may result in loss of revenue or fraud investigations leading to sanctions, penalties, and exclusion from participation in government programs. Review your charges and compare them to payments. If you notice receipt of full or almost full payment for a service, it is time to adjust your charge master. Somewhere along the line the procedure was re-valued by the payer(s) and you missed it. Speaking of charge masters, review yours annually to add new current procedural terminology (CPT) codes and remove outdated ones so that claims payment is not delayed. It is also a wise move for the billing staff and the physician to develop a good working relationship and spend time educating each other. The billing staff needs to fully understand the services our physicians perform. The physician must depend on and learn the multitude of billing rules from the coder. Each of them working together will ensure that every service was documented and billed correctly.

Insurance/patient billing: If you have done everything right so far, you should be almost ready to send a "clean" claim out for payment. The coverage has been verified, copies of insurance cards and signatures are on file, all charges are captured and documented and the right CPT codes and charges are recorded on the claim. Consider using prebilling edit or "claim scrubber" software to review your claim. Little things like missing a digit on a code, a date of birth, a medically inconsistent CPT code, not identifying the patient's sex, etc can all cause a claim to be returned to you for more information resulting in unnecessary delays. If your billing system provides for electronic billing and payment posting, use it at every opportunity. It is fast, efficient, and accurate.

Good billing software often includes "scrubbers," which identify obvious technical problems such as a miss match between the CPT code and the national Classification of Diseases–9th Revision–Clinical Modification (ICD) code. Some practice management software allows for automated tracking of any variance between contracted rates and insurance reimbursement.

Accounts receivable follow-up: Most often a claim is paid promptly and correctly, and we hardly notice because everything went smoothly and following our previous revenue cycle steps was rewarded. Since that is not always the case, we must be prepared to find out what went wrong. Typically, work files are created based on criteria the practice deems important. Most often it is best to work the newer, high dollar accounts first since these would be most likely to produce a positive result. However, all accounts should be worked with not only the goal of ultimate. Collection in mind, but also to determine what previous effort failed and how it can be reinforced in the future Tracking AR is traditionally done by counting the days since the date of the service. Charges and collections are trended monthly. The problem is that unless someone gets into each account detail, it is hard to tell whether steps have been taken to resolve the account. A different method is to re-age or recalibrate the account by when the account was last acted upon and then sort active denials, accounts with a credit balance, uncoded claims, and claims past due into a priority queue.The staff works with third party payers every day. They should be cultivating relationships with them since they will be the ones able to determine what needs to be corrected to get a claim paid or cut through the red tape. Amounts due from patients may represent a small percentage of an individual claim, but collectively they add up quickly to substantial sums. These smaller balances need to be pursued although we need to be alert to wasted effort and expending more time and funds than the account is worth. Often it is wiser to write off the small balance and consider the possibility of recovery sometime in the future on a subsequent visit. For higher balance accounts, there should be a policy in place that sets forth a formula for reasonable fixed payments over a predetermined time span. A requirement to pay in too short a time with high payments will fail. Low payments over extended periods of time will eventually result in payments slowing and then ceasing completely. This might be a good time to consider offering a discount for a lump sum settlement to resolve the debt. This will help determine whether they can afford the terms you propose. It benefits no one to propose a payment plan that has no hope of succeeding. Finally, do not allow insurance denials to get out of hand. Often denials occur due to some small error, such as the transposition of numbers. These errors are easily resolved. In other cases, additional claims documentation or a letter from the physician will be needed to appeal a rejection. In some cases, it may be necessary for the physician to personally discuss the issues with the payer medical director. Depending on the administrative structure in the practice, someone will be given the authority to write off contractual adjustments and other bad debts. Refunds need to be processed just as judiciously as accounts receivable. They really do not belong to the practice and can make it appear that accounts receivable are lower than they actually are. Government payers, as well as the courts, often consider this a fraud and abuse issue.

Benchmarking: Without accurate and timely steps as outlined, none of the financial tools necessary for critical practice analysis such as charges or cost per relative value unit (RVU) or work RVU (wRVU), revenue per RVU, break-even fees, practice expense RVU (peRVU), profitability will be accurate. If we have followed our outline, our financial performance should produce a positive bottom line and a strong financial base. Key indicators of value to any practice would include the net collection rate, days in accounts receivable, charge lag days, denial rates, collection per RVU, bad debt etc. A standard report should consist of total charges, dollar amount submitted for payment, amounts paid/ adjusted/written off with a breakdown by physician, facility, CPT code, and payer. An aging report with accounts receivables at 30, 60, and 120 days and beyond should be required . As mentioned earlier, aging by the most recent activity on the account is helpful. If the software allows, a variance report of agreed upon payment rates and actual insurance payment is also most useful. Overhead costs should be reviewed on at least a quarterly basis keeping in mind that overzealously trying to reduce overhead could produce negative results. Investing a little extra to obtain better information or that extra call to an third party payer may be worth a great deal more than saving a few staffing dollars.

Table: Common metrics and benchmarks in a revenue cycle

Parameter	Metric	Formula	Benchmark (for surgery practices)
Patient access	% of patients with complete and accurate preregistration information Compliance with physician authorization requirement	Complete preregistrations/total registrations	96%-98%

Billing	Charge lag time Clean claims submitted Overturn of denials Paper remittances	Average # days from date of service/discharge to posting data Average # days from date of service/discharge to posting data Paper remittances/all posted charges	<7 95% 95%
Cash management	Month's revenue in accounts receivable	Accounts receivable (from balance sheet) Average Monthly gross revenues .	
	Gross collection ratio	Cash received from payers and customers(cash-flow statement) / Gross fees (from income statement)	Median 41.6%
	Net collection ratio	Cash received from payers and customers(cash-flow statement) / Net fees (from income statement)	Median 94%
Accounts receivable/ collection	Posting of cash and contractual allowance		<24 hours
	Average payment period	Current liabilities / (Total expenses- Depreciation)/ 365	
	Average collection period or days in patients accounts receivable Accounts receivables	Net patient accounts receivable (from balance sheet) / Patient service revenue/365	Median 47.1 days
Expenses	Cost to collect Bad debt expense	Total cost of all business related functions total collections 88% of gross or net revenue	Median 22.3%
	Overhead %	Total non-physician expenses as % of total / Cash collections or net revenue	<5%
		Total non-physician expense / Total net revenue	

DISCUSSION

The above outline was not intended to detail every aspect of the revenue cycle, but to be a reminder that a common sense, orderly and consistent approach to producing financial stability is not an option. As an owner of your practice, you are undoubtedly familiar with some parts of the general process of the revenue cycle. But, since the survival of the practice depends on the most efficient and accurate process, additional time spent on learning about the details of the financial report and how your practice compares with benchmarks is worth the extra effort. With overhead expenses climbing and margins narrowing, even a 1% or 2% improvement in collections could make a big difference to your bottom-line.

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