An introduction to

Revenue Cycle Management

A riveting ebook by **rivet**

What is the revenue cycle?

The revenue cycle and revenue cycle management (RCM) are the terms used to describe the process by which healthcare systems track revenue coming into their practice, from both patients and health insurance companies (often called 'payers' or 'payors'). What is generally referred to as a "transaction" to the rest of the business world is not so simple in healthcare.

In this guide, we'll walk through each individual component of the revenue cycle and have a candid discussion of potential challenges, ideas, technologies, and strategies for each stage in the revenue cycle.

CONTENTS

Pre-claim and administrative duties

Many people think of the revenue cycle as a linear progression of events, starting with scheduling and ending with collections. While that is somewhat true, it also leaves out crucial pieces of the revenue cycle and pivotal components when it comes to practice revenue: Contract negotiations, fee schedules, credentialing, and EDI/ERA enrollment. Being on the front lines of a busy practice, it can be easy to let this portion of the revenue cycle slide, but the best practices understand this portion like the back of their hand. First, let's dive into contracts with the health insurance companies or payer (or payor) contracts.

PAYER CONTRACT NEGOTIATION

Every practice has unique relationships with each of their health insurance partners. Generally speaking, those partnerships are what determine whether or not a provider is "in-network" or "out-of-network" for that practice's patients. Relationships with commercial payers can be messy and challenging to keep up -- many publish amendments, re-credentialing requirements, and

reimbursement changes that could impact the bottom line.

Commercial payers are any health insurance company that aren't controlled by government programs such as the Centers for Medicare and Medicaid Services (CMS). In these relationships, the terms are dictated by payer contracts. It is important to know that contracts are not set in stone and many components can be negotiated. Practices need to understand the unique offerings that make them valuable to payer networks and use that value to ask for better contract terms, and possibly higher negotiated rates. Those practices that clearly understand and negotiate the terms of their individual contracts are at a distinct advantage and will be less likely to leave money on the table for their practice.

FEE SCHEDULES

Fee schedules are a set of reimbursement rates defined by payers that define how much a practice will be paid for a service based on which codes are involved, location of service, provider type, etc. There are several different classes of fee schedules: MedicAare, Medicaid, commercial, and government replacement plans. Fee schedules vary based on each individual payer and even different plan types that payers may offer. While most Medicare and Medicaid fee schedules are available online through payer portals, commercial fee schedules are notoriously challenging to track down and keep updated. These schedules are a major component to ensure practices are compensated for the care that is provided. Often, contracted or negotiated rates for an in-network provider are less than that charged by healthcare providers. By leveraging up-to-date fee schedules, providers can strategically set their billed charges at a rate that

maximizes the payout from each health insurance company while reducing the consumer sticker shock associated with many procedures.

CREDENTIALING

To bill an insurance carrier, providers or groups must go through the credentialing process. Credentialing gives a practice eligibility to bill insurance and is one of the key drivers behind what makes a provider "in-network". In the credentialing process, practices obtain and evaluate documentation regarding provider education, training, work history, licensure, regulatory compliance, and malpractice history before allowing them to participate in a network or treat patients. The types of verification required for credentialing vary by carrier, so be sure to understand what is required and swiftly comply with all requests. Simply put, providers should not perform, and will likely not get compensated for, any services without proper credentialing.

EDI ENROLLMENT

Submitting claims to the insurance company is ultimately how you will get paid by insurance carriers. With insurance companies accepting more electronic transactions, practices must enroll with an electronic data interchange (EDI) vendor to send claims electronically. EDI vendors are essentially clearinghouses that take claims and electronically submit them to payers in the form of an 837 file. The vendor will then receive electronic remittance advice (ERA), also known as 835 payment files, in a digital format from insurance carriers. ERA files provide claim payment information and typically enable an efficient cash posting process into the practice billing system.

There are many benefits of using a clearinghouse or EDI vendor, including reduced claim rejections, higher clean claim rate and lower, denial, and cash posting errors.

Pre-visit

Now to introduce the patient into the revenue cycle mix. Pre-visit typically includes scheduling, registration, and verifying patient insurance. A lot can (and should) be done upfront to minimize friction in the collections process, drive more practice revenue, and get providers paid.

SCHEDULING AND REGISTRATION

Maintaining an efficient flow of patients is extremely valuable to the revenue cycle. Effective scheduling will reduce missed appointments, avoiding the loss of revenue in the process. Patient reminders and the proper handling of cancelled appointments will keep providers productive and lead to more revenue for the practice. The scheduling process should also include the communication of any additional appointment requirements and setting payment expectations.

Then on to the registration process, which is sneaky important to the revenue cycle. While gathering patient data seems relatively straight forward, the accuracy of that information could influence claim denials, collections, and ultimately the

amount (or lack) of revenue generated from the visit. Developing quality assurance processes for collecting patient demographics is one of the most efficient ways to reduce claim denials later on in the revenue cycle.

PATIENT ELIGIBILITY, ESTIMATES, AND COLLECTING UPFRONT

Ensuring that a patient's insurance plan and benefits are compatible with the services being provided is a best practice during registration or scheduling process. Not only does an eligibility check help verify correct patient data, it can also avoid insurance claim denials and unaffordable out-of-pocket costs for the patient.

One of the hottest topics in healthcare today is pricing transparency. The newest eligibility best-practice includes providing accurate estimates and payment opportunities prior to care. Accurate upfront estimates provide patients with transparent pricing and improved understanding of services being provided. Upfront payments improve the patient experience by helping them know costs, paying prior to care, and removing surprise bills from the equation. On the practice side, with high deductible health plans, patients have become payers. Good business means increasing meaningful financial touchpoints as early on as possible to reduce the risk of failed collections. This can be especially simple and effective for routine codes and services and will help to lower your patient bad debt.

Point of service

Although the patient was just introduced in the revenue cycle, the point of service is the last line of defense for making sure the practice has everything it needs from the patient. During this time, providers should confirm that they have all the correct data and supporting documents and that the patient has all the information they need. The visit consists of check-in and copay collection.

CHECK-IN

Checking in upon arrival is a great opportunity for the patient to enter or confirm their personal information. The front desk may also scan photo ID and insurance cards into the system should an error be found later. Many practices now use kiosks and tablets that interface with their practice management system (PMS), allowing a more automated and streamlined check-in experience. Additionally, this is another opportunity to verify eligibility and request upfront payment. By some estimates, the likelihood of receiving a patient payment drops as much as 60% following the visit.

COPAY COLLECTION

Assuming the practice doesn't collect a percentage or the entire patient payment upfront, be sure to collect the patient copay prior to the procedure or service. In this new landscape of healthcare, the ability to collect patient copays and deductibles is crucial to effectively manage the revenue cycle. Regarding copays, practices should be sure to communicate expectations to the patient prior to the visit that payment is expected at the time of the visit. This is also a time for the front desk to walk the patient through their insurance and financial responsibility.

Claim submission

Following the patient visit, the back office processes begin. This is where medical billing really starts. Precise processes in this phase will allow the practice to successfully communicate pertinent information to the insurance company. This phase includes charge capture and coding, bill scrubbing, and submitting the claim through a clearinghouse.

CHARGE CAPTURE AND CODING

Charge capture is the process that begins the documentation of the visit for the insurance company to ensure they get paid for their services. When the visit ends, the medical record should be updated and procedure codes should be assigned for claims. From there, the codes are translated into charges that will be sent out to the specific insurance carrier. Thorough and accurate charge capture is another vital step towards ensuring complete payment from the payer. Undercoding charges can result in a practice not being paid what it deserves and overcoding charges can overinflate revenue numbers and result in costly audits or medical necessity denials.

BILL SCRUBBING

Unfortunately, medical coding is extremely difficult and therefore errors are often common. Medical bill scrubbing is the process of checking for common errors and validating the accuracy of claims prior to submitting the claim to the health insurance company. Claims are routinely rejected or denied for the slightest of errors, so claim scrubbing is an additional step to ensure claims are clean and avoid processing error headaches. Bill editing and scrubbing can be done by practices, clearinghouses, or other vendors. One helpful tip is that many vendors allow a practice to create custom billing rules - so evaluating top rejections and denials is a good place to start in creating these rules.

CLAIM SUBMISSION

Once a claim is all cleaned up and ready for the payer (or clearinghouse), the time has come to submit the claim. Ideally this would be submitted electronically through the practice's EDI platform for processing and payment using 837 files. Most payers have time filing deadlines of 90-180 days after the date of service to submit the claim. The quick submission of claims will help avoid payment denial for late submissions.

Payment processing

Following a successful adjudication process, the payer sends the 835 files to the practice (ideally, electronically). The 835 files, or electronic remittance advice (ERA), provides claim payment information. Using these files, the practice or clearinghouse can post claim payments into their system. It is important to note that 835 files do not always match the 837 the practice sent. The 835 files contain the result of adjudication showing:

- Whether charges were paid, changed, or denied

- Patient responsibility, including deductible, co-insurance, and co-pay amounts

- Bundling and splitting of claims

- Payment method

Also note that the 835 and 837 files are protected by the Health Insurance Portability and Accountability Act (HIPAA), meaning they contain confidential patient information and should be handled in a compliant manner.

Accounts receivable

When a practice has provided a service and billed for said service, that's when accounts receivable (A/R) comes in. A/R is money owed by patients or payers. The end goal of revenue cycle management is to successfully reduce A/R days or buckets, ensuring payment and bringing in revenue for the practice.

PAYER ACCOUNTS RECEIVABLE

When a claim is submitted to the insurance company, they return with a claim status: accepted, rejected, or pending. Acceptance signals that the payer will move forward with adjudication (prior to the 835). In the adjudication process, insurance companies compare claims to patient benefits and coverage requirements. From there the claim will either be paid or denied. For denials, practices should have efficient denials management processes in place to run appeals, claim follow-up, and minimization of these scenarios. When a claim is rejected, it means that the claim (or bill) needs to be corrected and resubmitted. Practices should promptly report on these rejections and quickly move forward with correcting and resubmitting the claim.

PATIENT ACCOUNTS RECEIVABLE

Patient accounts receivable is the money owed by patients. Recently, due to high deductible health plans, practices have begun to see patient A/R increase substantially. Practices can no longer afford to write off large percentages of patient A/R. Modern processes and technology that involve upfront payments, smart messaging functionality, and thoughtful follow-up make it easier for patients to pay and go a long way in keeping patient A/R down.

COLLECTIONS

In the event that patient collection strategies and efforts do not yield payment, practices can turn to collections agencies as a last resort. While not ideal, a reputable collections company can collaborate with the practice and its patients to collect practice debt in a thoughtful, non-intrusive way.

Revenue cycle reporting

Throughout the end-to-end revenue cycle, there are a multitude of data points that indicate performance frequently referred to as Key Performance Indicators, or KPIs. Successful management of the revenue cycle will be predicated on a practice's ability to navigate and leverage the data to improve every step of the process. There are many data analytics tools that can help, but a practice can start by selecting what metrics to track and what tools and data are currently available. Cash collections, patient satisfaction, quality (PQRS/MIPS), A/R, denials analysis, and provider performance are good categories to start with. Consistently tracking this data and implementing process improvements can make all the difference in successful revenue cycle management.