Pulse RCM™

Revenue Cycle Management White Paper

Driving Next-Level Revenue Cycle Performance:
5 Strategies for Physician Practices

Revenue cycle management (RCM) is the lifeblood of any physician practice—and one of the top challenges practices face.

High-deductible plans continue to challenge cash-strapped consumers. **Eighty-three percent** of physician practices with five or fewer physicians reported that **delayed payment** from patients with high deductibles is their biggest revenue cycle challenge. Many of the survey respondents—including nearly 1,600 physician practices—are turning to new technologies and processes to recover monies owed.

Meanwhile, commercial payers are scrutinizing more claims than ever. A recent report revealed big differences between five major national payers when it comes to average time to payment and denial rates. Such differences make it more challenging for physician practices to collect monies owed.

And while healthcare organizations of all types recognize the importance of providing consumer-friendly payment options, **only 14 percent of providers** use advanced modeling tools to predict patients' ability to pay. This limits the ability of front-office staff to have financial discussions at the point of service, when patient financial engagement is highest.

Achieving next-level physician revenue cycle performance will require physician practices to invest in processes and technologies that support revenue integrity and increased patient financial engagement. Five strategies are key.

1 Strengthen coding capabilities.

Coding accuracy is critical to achieving revenue integrity. Yet, physician practices frequently face coding challenges, including:

- Undercoding claims, which occurs when physicians select codes that do not fully reflect the intensity of the work performed *(typically out of fear that the claim will be denied)*
- Neglecting to update old codes or include codes for specific services in the electronic health record (EHR)
- Lack of familiarity with coding nuances, such as those related to Medicare or specialty-specific coding
- Failing to demonstrate medical necessity

> "Hiring a certified professional coder is key to making sure claims are clean before they go out the door," says Samantha Meyer, director of revenue cycle management for Pulse. "A certified professional coder can provide education to physicians on the correct codes to support clean claims. This helps ensure revenue integrity and speeds payment times."

For certain specialties, such as orthopedics, neurosurgery and family practice, having access to certified professional coders—whether onsite or through a vendor—is critical to keeping up with coding updates, Meyer says. Support for pain management coding also is critical, not just because of the complexity of coding, but also due to increased scrutiny of pain management claims as the nation seeks to address the growing opioid epidemic.

Meyer recommends practices of **25 physicians hire at least two certified professional coders**. "Specialty practices may wish to hire more certified professional coders to stay on top of coding updates and provide one-on-one education to physicians," she says.

Practices also may wish to consider investing in claims-scrubbing software that can spot claims errors and omissions before claims are submitted and prompt staff for follow-up. When selecting a claims scrubber, look for a solution that achieves at least 95 percent claim acceptance on the first pass.

2 Review patient collections policies, technologies and procedures to support increased point-of-service collections and reduce unpaid accounts.

For example: Has your patient collections policy been reviewed in the past two years? If not, it may be time for a refresh. According to the Healthcare Financial Management Association, such a policy should define:

- The financial information that should be provided to patients
- How the information should be communicated
- The types of payment plans available
- Details regarding the practice's financial assistance policy, including eligibility requirements and how to apply for assistance

Another important consideration for practice leaders is to gauge how often your practice automatically generates estimates of patient responsibility at the point of care. Accurately estimating a patient's out-of-pocket costs at the point of service better positions front-desk staff to collect payments upfront and to initiate financial counseling, where needed. Today, **63 percent of healthcare providers** use cost-of-care estimation tools as a consumer-friendly means of prompting patient payment.

Now may also be the time to consider implementing advanced modeling tools to predict patient's propensity to pay. Some solutions predict propensity to pay at the point of service within a few minutes. The data received gives staff an opportunity to establish payment plans, where needed. In instances where patients qualify for outside financial assistance, some RCM technologies also give staff the tools they need to help patients apply for assistance at the point of care.

3 Continually look for ways to reduce days in accounts receivable (A/R).

When claims or patient billing statements are not accurate, patients' frustration increases—and so does days in A/R, the average number of days it takes for an organization to be paid the amount due. In addition to hiring a certified professional coder and using a claims scrubber, Meyer offers the following tips for reducing days in A/R.

Post charges on a daily basis. Insurance companies place time limits on claims submission (e.g., 90 days from the date of service). These deadlines vary by payer. When providers miss the timely filing deadline, the claim is denied—and the provider loses its right to appeal. "We've seen one instance where a charge was inputted three months after the date of service," Meyer says. "The provider faced issues with timely filing, resulting in lost revenue." Posting daily charges helps ensure the physician practice meets all deadlines for claims submission.

Follow up with payers each time you submit a claim. "It's important to reach out to the payer soon after claims submission to make sure the claim was received," Meyer says. "The best practice for follow-up communication with payers is within the first 30 days of claims submission. However, the most successful practices follow up with payers within five days of claims submission."

Work denials daily. **Ninety percent of claims denials are preventable**, and two-thirds can be corrected, according to The Advisory Board. Be diligent in appealing denials, and continually look for patterns that could point to the need for "Denials 101" education, such as commonalities in the types of denials received and their root causes.

Automate payment posting. Set up all payers for electronic funds transfer to facilitate more timely payment.

Case study:
Reclaim Physicians Medical Group

Reclaim is a multidisciplinary, medically integrated physician group headquartered in Grapevine, Texas. In 2014, 52 percent of claims had not been paid in more than 120 days, and days in A/R was higher than expected.

Reclaim had long struggled with denials. Inaccurate coding led to many denials: It wasn't uncommon for current procedural terminology (CPT) modifiers to be processed incorrectly, and in some instances, CPT codes were not linked correctly to specific procedures. Practice leaders also questioned whether the partners it had hired for RCM services were fully handling their financial responsibilities.

Additionally, point-of-service collections were low, primarily because the data in the patient ledger didn't match patients' explanation-of-benefits statements. Patients were less likely to pay claims because they didn't trust that the amount billed by the physician group. Patient frustration was high—and so was frustration among staff.

That year, Reclaim selected a new RCM vendor based on the vendor's more than 20-year track record of success in working with insurance carriers, managing claims and resolving electronic data interchange claim rejections. The vendor was the fifth that Reclaim had worked with in recent years, but the level of expertise this vendor brought to the practice quickly helped staff adjust revenue cycle workflows to industry best practice across the physician group's 22 offices.

The results have been outstanding:

- By standardizing workflows according to industry best practice, Reclaim reduced days in A/R by half. "By the end of December 2017, more than 60 percent of our A/R fell under the 0 to 90-day buckets," says Dar Griffeth, DC, chief operations officer for Reclaim. "Meanwhile, our average days in A/R totaled 38 days—an outstanding achievement."
- Point-of-service collections have increased more than 12 percent since 2015, and patient complaints have been reduced by half.
- Automated system improvements generate more accurate, actionable data, increasing efficiency and the practice's clean claims rate.
- Denials also have significantly decreased.

> "What really spoke to our staff was the turnaround in days in A/R and how quickly claims are being paid," Dr. Griffeth says. "Claims are approved sooner, with fewer complications, and days in A/R have been cut in half. Additionally, our staff is able to view specific performance metrics at any time. This increases transparency while generating excitement around the progress we've made."

4 Reexamine revenue cycle workflows to determine where inefficiencies exist.

> "Even high performers have opportunities for improvements in workflow, accuracy and efficiency," says Samantha Meyer of Pulse. "Consider partnering with an expert to review processes from the front end to the back for opportunities to enhance revenue cycle performance."

In reviewing your practice's revenue cycle workflows, key areas of focus should include the following:

- Determine whether your practice's fee schedules are up to date. Keeping your fee schedules up to date will help in identifying whether payers are paying the negotiated rates for services. It will also provide a basis for comparison in negotiating in-network rates with commercial payers. Practices also may use their fee schedules to assess aspects of revenue cycle performance, such as charges per encounter.
- Ensure payer contracts are updated at least once every two years. Doing so is critical to keeping reimbursement rates in line with market rates. Regular reviews also ensure contracts do not collect dust, putting physician practices at risk of collecting lower revenue than appropriate for the market.
- Evaluate the efficiency of your prior authorization processes. Investing in automated tools that prompt physicians and staff for documentation that supports prior authorization requests could increase efficiency and speed approval.

Case Study:
Midwest Orthopaedic Center

Midwest Orthopaedic Center, based in Peoria, Ill., is one of the largest and most diverse orthopaedic groups in central Illinois. In 2011, Midwest Orthopaedic sought to gain greater visibility into its revenue cycle processes and performance. Leaders also wanted to better position the practice to perform well under value-based business models and contracts and accept greater levels of risk.

Midwest Orthopaedic undertook a comprehensive review of the organization's revenue cycle technologies and workflows, looking for opportunities to improve processes and automate workflows for increased efficiency. Ultimately, the practice invested in a new practice management system, an EHR, a data-mining tool and a suite of revenue cycle management services to boost performance and productivity.

"The revenue cycle management solution we chose not only optimizes our workflow, but also enables us to provide better-quality care," says Derek Armstrong, chief executive officer of Midwest Orthopaedic Center.

Access to real-time data provides leaders with a high degree of transparency into performance of specific accounts and the progress being made toward the practice's goals.

Soon after implementation, the practice achieved a **97.7 percent clean claims rate on first pass**. Its cash flow also significantly improved, bringing revenue in the door more quickly. "I can see what accounts have been touched and the status of certain worklists at a glance, and the reporting functionality is very robust," Armstrong says. "We've realized an increase in our charges as well as a significant increase in our receipts."

The success Midwest Orthopaedic continues to experience from reevaluating and reinvigorating its revenue cycle workflows is key to maintaining sustainability and agility in an era of transformation in healthcare.

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5 Look for ways to support strong revenue cycle performance and high transparency prior to entering a partnership or affiliation.

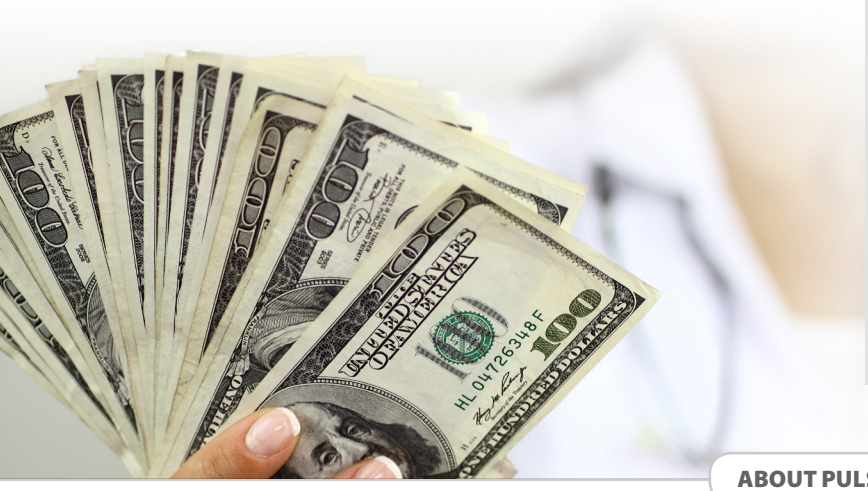
Today, nearly 56 percent of physicians work in practices owned by physicians, according to American Medical Association research. Consolidation among independent physician practices—both with other practices and with hospitals, health systems or companies—is increasing, often to reduce the burden of administrative tasks in an era of value.

If your practice is considering a potential partnership or merger, take the time to position the new entity for revenue cycle success before the relationship is formed, Meyer says.

> "Collaboration and communication are key," she says. "Work with practice administrators to streamline workflows at all practice locations. Ensure access to robust reporting capabilities, and develop a strategy for sharing data regularly with physicians and key staff. High levels of transparency around revenue cycle performance are key to gaining trust from key stakeholders as well as buy-in."

Make sure, too, that physicians have a solid understanding of the ways in which credentialing standards and processes may change under the new entity, if at all.

Organizations also may wish to engage an outside consultant to determine where additional revenue cycle training or technologies may be needed prior to moving forward with a partnership or merger. Doing so helps to set the newly formed organization up for success prior to go-live..



A Game Plan for Improved Revenue Integrity

Achieving next-level revenue cycle performance in an era of increased financial challenges for physician practices requires diligence, creativity and determination.

Look for ways to leverage existing technologies while keeping an eye toward new solutions that meet your practice's needs. Maintain a team mindset in partnering with a consultant or vendor to boost your practice's revenue cycle performance, and engage physicians and staff in pinpointing opportunities for improvement, sharing data regularly.

> "It all boils down to revenue integrity – ensuring your organization is paid appropriately for the care it provides to the communities you serve," Meyer says. "When physician practices invest in enhanced revenue cycle performance, they strengthen their ability to improve quality of care and outcomes. That's a value differentiator for physician practices, now and in the future."

ABOUT PULSE

Pulse is a Revenue Cycle Management (RCM) company with advanced medical billing services and technologies that help physicians get paid, simply work and improve the delivery of patient services. Pulse is recognized as a leading provider of SaaS and mobile solutions including integrated Electronic Health Records (EHR), Practice Management (PM), population health, electronic prescription, medical billing clearinghouse, patient engagement, and payment technologies to physicians, medical service providers and patients. Thousands of providers across over 40 specialties use Pulse to ensure they achieve the best possible financial and clinical outcomes.

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