

Outsource or Build it Yourself?

RCM Considerations for Your Practice.

**Take the RCM
Self Assessment
on page 9!**



The efficiency of a medical practice's billing operations has a critical impact on financial performance. Determining the ultimate gatekeepers of the billing function – whether an in house team or a third party company – is one of your most important decisions. This paper discusses the key drivers of your revenue cycle, and provides a tool to help you determine if your practice is proficient at Revenue Cycle Management (RCM), or if you would benefit by outsourcing billing to a third party.

Your Revenue Drivers:

Beyond just tracking a claim, your revenue cycle encompasses all the many steps from when a patient first makes an appointment to the time when there is no longer a balance on that person's account. It includes front-end office tasks like appointment scheduling and insurance eligibility verification; tasks related to clinical care like coding and charge capture; and back office tasks like claims submission, payment posting, statement processing and the management of denied claims. The extent to which your practice has a handle on these steps directly impacts your ability to get paid the full amount you are owed as quickly as possible.

Some of the factors that directly affect revenue in your practice include:

- Provider productivity
- Patient volume
- Fees for services
- Insurance claims (from private and government payers)
- Patient payments (deductibles, self pay), and
- Collections

Internal revenue drivers like provider capacity, patient volume and what you charge for your services are, for the most part, well within a medical practice's control. The typical medical practice is less effective when it comes to managing external revenue drivers, including payer reimbursements, patient payments and collections. Unfortunately, the odds of being optimal in these areas are stacked against you because the very nature of the way that most medical practices bill for services lends itself to lengthy payment cycles. Very few bills are processed at the point of service, but instead are bounced around from the payers to the practice to the patient over a number of months, if not longer – before finally either being collected or written off. By focusing on external drivers of revenue – that is, your payments and collections, you can optimize your revenue cycle and have a healthier cash flow.

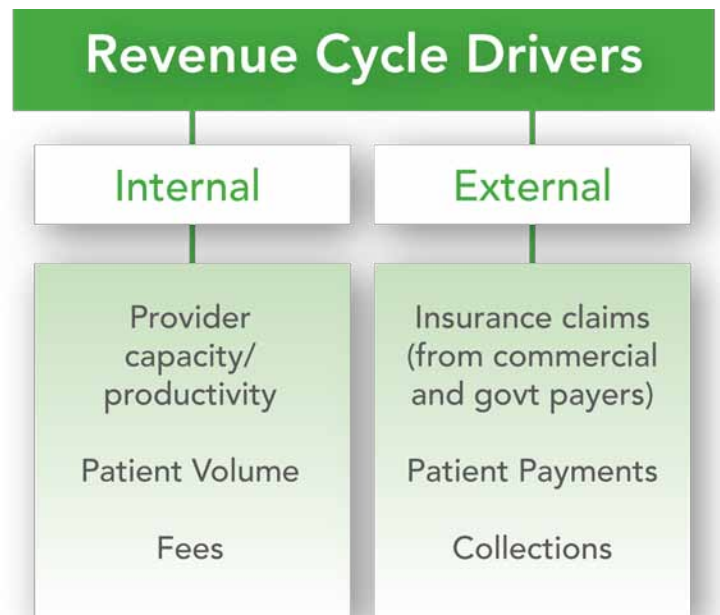


Figure 1

Payments and Collections: Your Bread and Butter

Payments: Getting Your Share of the Pie.

If you consider your payments as a pie, it would include anything that patients pay out of pocket (including deductibles and copays), as well as reimbursements from payers for covered services. Because claims reimbursement comprises the lion's share of the pie in most practices,ⁱ the speed and efficiency in which you turn claims into cash can determine whether or not your practice thrives. Effective claims management not only requires an understanding of how to negotiate payer contracts, but depends on familiarity with the complex and proprietary rules of each insurance company, knowledge of correct coding and timely filing methodologies, experience appealing rejected claims, and application of best practices for tracking and monitoring like charge capture audits and benchmarking.

Claims that are paid below contracted rates, or services that are never even billed due to inefficiencies in the billing process can negatively impact revenue, as can claims that are submitted but not accepted by payers because they did not meet specific payer requirements. Even practices with a well-oiled billing function can experience a claims rejection rate of 10 percent on first pass, with even higher rejection rates for more complex patient visitsⁱⁱ. With a refiling cost of up to \$25ⁱⁱⁱ per claim (some industry sources put this figure even higher), claims adjudication can become an expensive proposition (See Figure 2). Thus, the better optimized your claims submission machine, the better your first-pass payment rate, and the shorter your billing cycle.

After revenue from claims reimbursements, the other portion of your patient services revenue comes from patient self pay, including co-pays, and deductibles. The total share that is the patient's responsibility has been increasing in recent years (up to 23% in a recent MGMA poll)^{iv}, and the Centers for Medicare and Medicaid (CMS) estimates it will continue along that path in response to trends toward more consumer-directed healthcare products (HSAs, HRAs), decreased insurance coverage, and higher overall deductibles.^v The 2010 Employer Benefits Survey found that the percentage of U.S. workers with deductibles higher than \$1,000 is now 27 percent^{vi}. Sources, frequency and amount of patient self pay are not only changing, but are leading to increased confusion among both patients and office staff about what is owed at the time of the visit, and what will be billed and owed later.

Figure 2: Refiling Costs



Data based on 4,000 encounters. Assumes \$1/claim processing fee, and \$25/claim refiling fee.

The complexities of insurance filing, coupled with the challenges related to patient self pay, means that you may have a large number of patients at any given time who carry balances. Your efficiency at collecting on your patient balances is the other critical driver of your practice's revenue.

Collections: Is a Penny Charged a Penny Earned?

While we have established that most practices' payments come from insurance, most of your collections efforts are likely to go toward corralling the balance that patients owe on their bills. There are typically two sources of money owed to your practice.

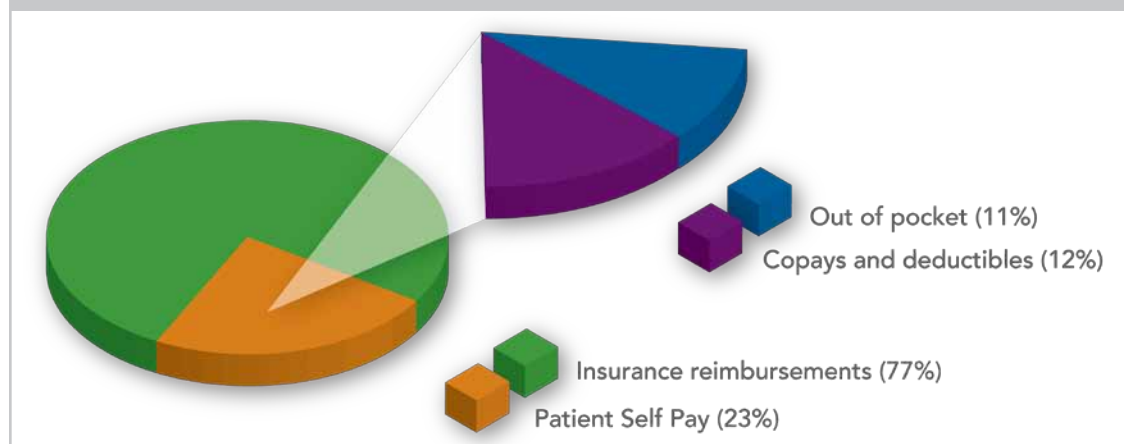
- The balance due after insurance companies have paid their portion, and
- Balances owed by patients for whom you never filed insurance, but who opted to pay out of pocket.

Post-insurance balances account for the fastest-growing component of medical practice bad debt,^{vii} according to a recent analysis of the U.S. health care payment system. To collect the maximum amount allowable under your payer contracts, it is important to monitor the outstanding accounts receivable aging for each insurance company in your payer mix. This requires dedicated resources who have time, diligence and a great deal of knowledge about the claims adjudication system and your practice's individual contractual terms so that you can more readily pick up on claims that are still outstanding beyond a typical or a contracted time frame, adjust fee schedules, and analyze the root cause of denials. It also involves handling appeals, identifying underpaid claims (which may be up to 6% of your total revenue^{viii}), following up with payers, and applying benchmarking techniques to ensure that you are as profitable as possible.

The other large chunk of accounts receivable for most practices stems from balances owed by patients for whom you never filed insurance, but who opted to pay out of pocket. A 2007 report on the healthcare payment system showed that 36 percent of patients have a past due balance of at least 60 days^{ix}, and MGMA data has found that 60 percent of the amount owed by patients is never collected. If you consider that 23 percent of your revenue comes from patient self pay (see Figure 3 below), and if you are only collecting 60 percent of those fees, you may be denying your practice as much as 14 percent of your total revenue. In light of the trend toward more patient self pay described

above, this challenge is not going away anytime soon. A 2009 report by research firm Celent based on CMS projections showed the likelihood of a health care debt burden that, unweighted, would amount to \$317,000 per medical practice by 2014.^x

Figure 3: Patient Services Revenue



Source: MGMA, Practice Perspective on Patient Payment Survey, 2009.

To mitigate these effects, practices are ideally collecting at both the front end and back end of the revenue cycle. Yet if you are like most practices, 30 percent of your patients pay nothing at all (not even a co-pay) at the time of service^{xi}. Combine that with the fact that nearly half (49%) of providers do not have the ability to calculate patients' financial responsibility, beyond co-payment, until after claims are submitted and processed,^{xii} and chances are good that you can get off to a bad start when the patient first comes through the door.

To keep your accounts receivable within a standard of 42 days^{xiii}, there is greater pressure on your billing team to correctly bill and collect from patients. Best practices like insurance eligibility verification, collecting co-pays up front, prior authorizations, managing referrals, as well as having defined financial policies in place and clearly communicating those to your patients, are instrumental in your ability to quickly get paid on money owed.

Tools in Your Bag: Ways You Can Influence Your Revenue Picture

When it comes to building a healthy bottom line, the bad news is that the current health care payment system is more or less structured to work against you. The complexities of medical insurance and the way that services are billed and collected are often counterproductive to your ability to get paid quickly. The good news, however, is that there are some ways that you can positively impact the extent to which you are getting paid the full amount from patients and providers, and thereby reduce the portion of your revenue that is in A/R. Strength in the following three areas is critical to a healthy medical billing function and associated strong revenue cycle.

Collections Odds:

It is estimated that accounts that are:

- 90 days past due are 90 percent collectible
- 180 days past due are 67 percent collectible
- 1 year old are 40 percent collectible

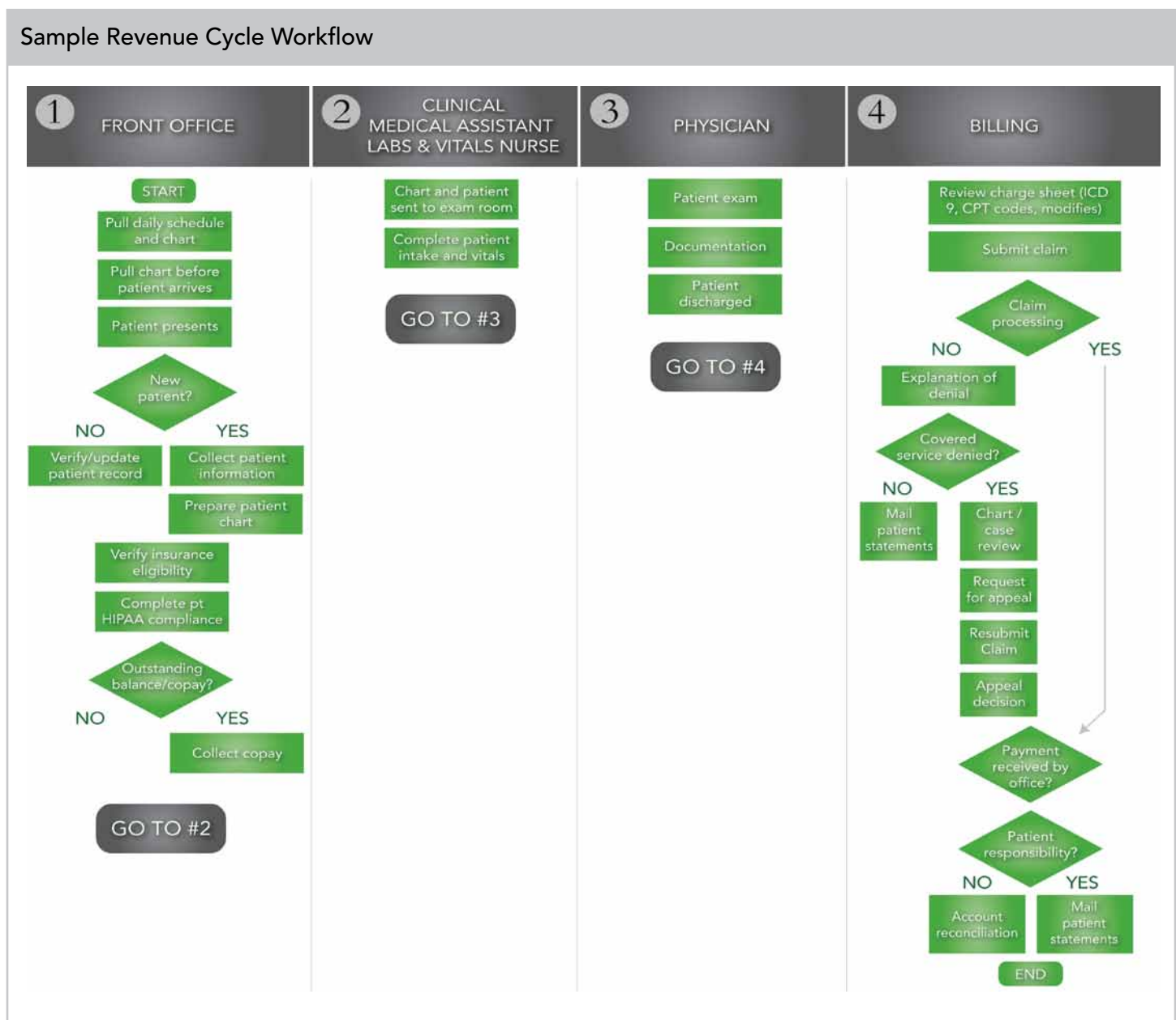
Source: The International Journal of Medical Banking.^{xiv}

Workflow.

Your revenue cycle workflow includes the activities within your practice related to billing. Front office tasks like verifying insurance or collecting a co-pay, documentation of the visit using appropriate diagnosis and procedure codes, and activities related to submitting the claim and then managing the collections process are all linked together like a chain. Just one small kink in the chain can throw off your revenue cycle and generally wreak havoc.

Having cohesive front and back office billing functions improves revenue because it creates time efficiencies, aids communication, and allows for appropriate oversight of coding and other billing processes.

The sample revenue cycle management workflow below shows the many interrelated steps in the payment process.



Use of Technology.

Medical providers have long embraced technology as integral to good clinical outcomes, but may not realize its vast potential for a practice's financial performance. If you consider the workflow on the previous page, health information technology like a practice management system or an electronic medical record, can be used in the following areas to optimize a practice's revenue cycle:

Front office

- Automated patient reminders reduce no-shows and help provider productivity.
- Insurance eligibility verified electronically can minimize billing delays and denials.
- Credit card processing of co-pays, deductibles or co-insurance payments at the time of the office visit increases the probability that you'll collect more of a patient's self-pay balance.

Patient visit

- An EMR can document the details of a patient encounter, and capture other relevant documentation that a biller would require to ensure reimbursement.
- Charge capture functionality can make sure providers input the appropriate diagnosis and procedure codes at the time of visit to send to the biller, who can then easily review the clinical notes to be sure that all codes are accurate.

Billing Functions

- Electronic claims can be submitted in real time directly to a clearinghouse.
- Claim status can be tracked, and claims can be scrubbed before they are submitted to payers to check that they meet national and local requirements for medical necessity and comply with commercial claims stipulations.
- Payments can be posted automatically to expedite the billing cycle.
- Key reports can give important insights on both a macro level (e.g. the profitability of your business), and a micro level (e.g. the profitability of a particular procedure), and help practices stay apprised of key RCM indicators.

Revenue, Compliance and Technology

Not having a strong compliance program can cost you. Penalties or audits that result in fines, denied reimbursement, and recovery auditor take-backs detract from your bottom line. Keeping abreast of the many state and federal regulations and laws that govern things like medical claims submission, electronic transactions, and coding can keep money in your account –and keep you out of legal hot water. Reduce your risk (and protect your pocket book) by making sure staff are savvy about compliance issues, and by using health information technology as a tool to keep your practice current with these and other regulations impacting medical practices today:

- The HITECH Act
- HIPAA (including new HITECH revisions with stiffer penalties)
- Various CMS regulations and mandates related to coding
- PQRI requirements
- Red Flags Rules and other legislation targeting fraud and abuse.

A Qualified Team.

Having a well-trained and experienced billing team is perhaps the most important indirect driver of revenue at your practice. Billers and coders who are credentialed and certified from reputable professional associations like the Healthcare Billing Management Association, American Health Information Management Association, or the American Academy of Professional Coders, not only know how to code for the highest revenue and understand best practices about billing that can help you avoid an audit, but also are better informed about important industry changes (e.g. – HIPAA updates, changes from the ICD-9 to ICD-10 disease classification series, etc.) that can impact your revenue and operations. Moreover, credentialed professionals can apply advanced principles that are likely to make a true difference in your cash flow, including benchmarking practices, analyzing remittance data to find variances from your payer contracts, and proactively uncovering or reverse-engineering payer rules.

Conclusion

Your reimbursements on claims filed and the money paid out of pocket by patients are the basis of your revenue cycle. The extent to which you effectively manage your payment processes and have a handle on collecting payments that are past due is an indicator of your practice's financial health. While this makes sense intuitively, actual execution of effective revenue cycle management is a challenge to the average practice owner. Not only is the U.S. health care payment system designed to work against you, but you may otherwise lack the time, expertise or internal systems to ensure that you get paid the maximum you are owed as quickly as possible.

Having appropriate technology, adequate workflow and experienced billing personnel are important steps on the path toward a prosperous and efficient practice. The more that you can integrate these assets into your billing function, the stronger influence you can have over financial outcomes. Practices that lack in these key areas may need to evaluate if they are candidates for outsourcing.

Alphabet Soup: A Healthy Dose Has Its Benefits

Delegating billing and coding tasks to qualified professionals can pay off. Separate studies conducted by both the U.S. Army^{xv} and the American Academy of Professional Coders (AAPC)^{xvi} have illustrated that professionally trained billers and coders are more likely to reduce denials and improve revenue. Yet 49 percent of medical practices^{xvii} are not using qualified professionals for important billing functions like review of COBs, EOBs and appeals. Tighten up your collections and payment management processes by looking for billers and coders with any of the following credentials:

- CCA
- CCS
- CHBME
- CHDA
- CHPS
- CMBA
- CMRS
- CPC
- CPC-H
- RHIA
- RHIT

To Outsource or Not to Outsource?: Conducting Your Analysis

You may be one of the few, fortunate medical practices that have a firm handle on your revenue cycle. But if you are like most practices today, you probably could use some help, or you're at least curious about whether there are things that you could – or should – be doing differently to jump-start your payments and rein in your collections.

The following assessment tool can help you determine:

- Whether you are a master of the RCM domain
- If your processes and staffing might require a few tweaks, or
- If you're a potential candidate for assistance from a third party billing services company

Self Assessment

	Yes	No	I don't know
1. Do you regularly verify eligibility at or before the patient visit?			
2. Do you regularly analyze remittance data to uncover variances in your payer contracts?			
3. Are you using ERA for more than 50% of payers?			
4. Do you employ/use a credentialed professional coder to oversee your billing process and suggest improvements?			
5. Is your net collections ratio at or above 96%?			
6. Are at least 93% of your claims accepted on the first pass?			
7. Are you getting paid within a 30-day window on claims submitted?			
8. Do ever compare your financial performance indicators against other similar size practices in your specialty?			
9. Do you get a monthly report with key financial business metrics?			
10. Are all claims filed daily?			
11. Are you using a claims scrubbing tool?			
12. Are you electronically filing claims to 75% of payers?			
13. Do you know the eligibility requirements to receive Medicare/Medicaid meaningful use incentive payments under the HITECH Act?			
14. Do you analyze revenue based on specific procedures performed in your practice?			
15. Do you regularly collect copays and deductibles at the patient visit?			
YOUR TOTAL SCORE:			

Score: 0-30

Score: 31-60

Score: 61-84

Score: 85-100

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