MPC, Inc.
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# Revenue Cycle Management

**"Revenue Cycle Management"** is the broad new name for managing "Accounts" in a Medical Practice.

"Revenue Cycle Management" has been defined as "All administrative and clinical functions that contribute to the capture, management, and collection of practice service revenue" by the Healthcare Financial Management Association (HFMA). It is a term that covers a patient account from the beginning to the end. Management means that practices get paid in full and in a timely manner.

The Cycle starts before the first charge is made for a patient visit. It begins when the patient first calls for an appointment. Getting accurate patient and insurance information is essential. Lack of good information shows up in the practice "Rejection and Denial" reports.

**REJECTIONS AND DENIALS**

There are benchmarks all through the process to determine whether or not a practice is billing accurately. For example a Rejection or Denial rate in excess of 3% is excessive even though some organizations are prepared to accept a 7% Rejection and Denial rate. It is helpful to run a Rejection and Denial Report once a month in order to bring the percentage down to an acceptable level.

Corrective action, in the meantime, should include making sure that the reasons for the Rejection or Denial are being addressed. If the reason is inaccurate demographic or insurance information make sure that this problem is corrected for the future when the appointment is made and also at the front desk.

**VERIFYING INSURANCE**

A practice cannot always verify a patients insurance coverage before the patient shows up for an appointment, however, insurance information needs to be verified before a patient is seen. Not all practices are asking patients for their insurance cards at every office visit; however most practices tend to do so now since patients insurance, including Medicare, changes frequently.

Most practices now have access, online, for verification of eligibility. Many practices use portals and patient registration devises to gain instant access to insurance verification.

**EXCESS A/R**

If the Rejection and Denial rate exceeds 3% and some practices have up to a 30% Rejection and Denial rate, then it becomes important for you to understand what happens when the rejection rate gets high.

First of all it will take another three (3) or four (4) weeks to get those Rejected and Denial claims paid. In other words as much as a quarter of your Revenue for insurance will be held up for at least three (3) to four (4) weeks. It will take time for your staff to work these Rejections and Denials. Considering what you pay your staff it could cost as much as $20.00 a claim to take corrective action. At that rate 200 to 300 claims can cost as much as $4,000 to $6,000 a month minimum or $48,000 to $72,000 a year.

Since Patient Sign In Sheets are still permitted provided they meet HIPAA requirements many practices are customizing their Sign In Sheets to ascertain whether or not changes have taken place, including changes in address, insurance, etcetera. For those practices a 98% accuracy benchmark for "clean claims" is normal.


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If you are on an efficient Practice Management software system there are many ways now that you can verify accurate demographic and insurance information, missing charges, inaccurate coding levels and medical necessity. Electronic claims submission and electronic remittance payment posting has proved to be a huge savings in staff time.

**HELPFUL TECHNOLOGY**

Online bill payment and e-statements has helped reduce the turnaround time on patient accounts. You will never have a zero accounts receivable balance because of the turnaround time on the insurance part of your Accounts Receivable (A/R). Typically you should not have more than 5% of your receivables over 90 days except for some very specific accounts such as Workers Compensation and Motor Vehicle Accident accounts.

**TIMELY PAYMENT**

The new approach is to ensure that every account that can be paid is paid at the time of service, that all insurance is verified ahead of time and that all claims (referred to as "clean claims") are paid within 30 days. Most States have a law requiring that clean claims are paid or denied within 30 to 45 days.

**MONITORING YOUR A/R**

Every practice needs to know how to analyze their operations to determine whether or not they are paid in a timely manner on all accounts.

To ensure that accounts are paid in a timely manner the practice needs to have financial policies which will ensure that result; have policies and procedures in place and have staff fully trained on those policies and procedures; have methods to quickly determine if the desired results are occurring and have benchmarks, such as some that are listed here, which are being met.

**MEDICAL PRACTICE BENCHMARKS**

Most doctors want to know how the business side of their practice compares with other practices in their specialty in their part of the country. There are a number of surveys which provide benchmark information including Medical Economics, MGMA, SMD and others.

The problem seems to be that the statistics for many practices do not compare closely with the survey benchmarks.

Some surveys are based on large institutions. Comparing a solo practice with large institutions won't work. Other surveys have a small number of practices to compare against. Again comparing a large group practice with smaller or solo practices will not provide meaningful information.

What needs to happen is that you compare apples with apples meaning that your practice needs to be compared with similar practices in your area. This is not always easy to do.

**THE PROVIDERS RULE**

No discussion of RCM would be complete without discussing the role of the provider. Billings starts with the provider providing a service. So often revenue is lost by not documenting appropriately and billing for the right level of E/M service. Many providers tend to downcode because of the fear of being audited. Generally in that case the provider is unsure as to whether or not the documentation will support the level of service.

It is appropriate for a provider to bill for the level of service provided that the service is documented. Two items which tend to help providers code and bill accurately are electronic coding tools, used properly, and templates, used appropriately.

In taking this approach the provider should have a good understanding of the Evaluation and Management Documentation Guidelines. By this we mean the provider needs to understand all the elements of History, Examination and Decision Making. That allows the provider to understand what he / she is "getting credit for" as the electronic coding tool, embedded in the background, "counts the bullets". The tricky part of the process is determining the level of complexity. Some electronic coding tools let the software make this determination. Some ask the provider to select the level. Some have medical necessity built in and some do not. By "medical necessity" we mean that the ICD code will support the level of service.

The Providers Role also extends into all areas of the rest of CPT. It is the provider's role to ensure that the codes selected for surgery, for instance, are accurate and that multiple procedures with modifiers are billed accurately.

It is in this one area, coding, that many times substantial revenue is lost before it ever gets billed out.

Templates, when used appropriately, are permissible. When not used appropriately serious issues arise. The most common form of not using templates appropriately is "cloning". Cloning means carrying forward a previous record but not taking the time to properly edit the template to accurately reflect the documentation for the new encounter. Many software vendors promote the use of carrying forward documentation from one visit to the next to save time documenting. Cloning has become a major issue with CMS.

***A best friend is like a four leaf clover: hard to find and lucky to have. ~Author Unknown***