MPM
METROPOLITAN PRACTICE MANAGEMENT

IMPROVE PRACTICE EFFICIENCY

7 Revenue Cycle Best Practices

nextgen healthcare | NextGen® Office

TABLE OF CONTENTS

Chapter 1: Self-pay collections....3

Chapter 2: Measuring performance....6

Chapter 3: Claims scrubbing....9

Chapter 4: Track and prevent denials.... 10

Chapter 5: Create and enforce write-off policy.... 12

Chapter 6: Remind patients of appointments.... 13

Chapter 7: Maximize electronic remittance advice.... 14

Now more than ever—consider a new approach to your revenue cycle

Effective revenue cycle management has become more critical for ambulatory medical practices because of the COVID-19 public health emergency. According to a survey from the Medical Group Management Association, 97% of medical practices experienced financial harm as a result of COVID-19. Fifty-five percent said revenue is down since the start of the crisis and 60% said patient volume is down.[1] Under such circumstances, practices need to be even more mindful of implementing the correct procedures for billing and practice management.

Medical practices need to consider both where they stand today and how they can best plan for the future. You can improve both your current situation and the long-term outlook with a focus on the right revenue cycle tactics and solutions. This E-book discusses steps you can take to ensure you're paid every dollar you deserve.

CHAPTER 1

SELF-PAY COLLECTIONS

Optimizing self-pay collections requires understanding where and how you can affect performance.

Check eligibility to get more money, faster

About 60% of Americans are insured through their employers. To cut costs, these employers are passing fees on to employees through increased copays, deductibles, coinsurances, and decreasing overall benefit coverage.

With patient deductibles and coinsurance increasing each year, patient collections can make or break the financial health of a practice. It all starts with checking a patient's eligibility. With a user-friendly tool, you can verify a patient's eligibility, plan specifics, and copays/deductibles.

It's important to check eligibility to:

- Obtain up-front collection of copays and deductibles
- Eliminate claim denials, claim resubmittals, and unpaid patient balances in accounts receivable (AR)

Execute self-pay best practices

- Check if patient does/does not have insurance
- Obtain accurate patient demographics data
- Provide front-end staff with training (and ample scripting) to increase comfort with point-of-service collections
- Implement creative ways to collect patient payments:
  - Kiosk technology
  - Patient portal
  - Electronic statements
  - Service refusal (to patients who owe money)

Patient collections workflow:

1 Appointment scheduling

- Collect demographics and identify uninsured patients
- Communicate financial policy
- $ Collect past-due balances

2 Pre-visit

- Verify insurance
- Qualify uninsured patients for charity care, Medicaid, or exchange
- Flag patients with bad debt

3 Check-in

- $ Collect copays
- $ Collect past-due balances
- $ Collect prompt-pay deposit
- Confirm financial agreements

4 Patient care

- Remind patient to stop at checkout

5 Checkout

- $ Collect copays and past due balances
- $ Collect cash-pay amount due
- Estimate patient responsibility

6 Follow-up

- $ Conduct over-due balance, out-bound patient calls; send statements and letters
- Establish/maintain consistent bad-debt policy
- Manage bad-dept vendor

$ Direct opportunity for cash collections

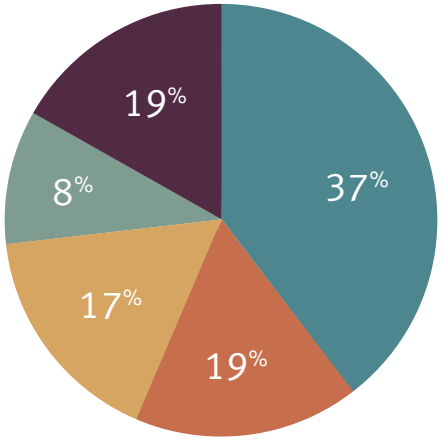
Incent patients for a win-win

Because patients pay their balances more slowly than payers, providers should incent patients to resolve balances quickly. Offering financial incentives to pay sooner is beneficial to both patient and provider.

Also, keep in mind that lack of payment may be due to a patient's inability to pay. Providers should also help patients resolve medical bills by offering financing options. Many patients may want to settle their balances when given a payment plan.

Patient reasons for nonpayment:

- Lack of financing options
- I just received my statement
- I forgot to pay or was confused about what I owe
- Healthcare is a right; I shouldn't have to pay my bill
- Other[1]



1 Includes responses that received <5% response (e.g., "I don't pay my bills until the provider or a collection agency calls me," "My provider doesn't accept my preferred method of payment," etc.)
Source: McKinsey Retail Healthcare Consumer Survey, 2009

CHAPTER 2

PERFORMANCE MEASUREMENT

Leverage AR transparency

Monitoring your revenue cycle allows you to compare key billing indicators from month to month and year to year. You can then measure your practice against industry and specialty standards.

Analysis of key performance indicators can help you find opportunities to improve business efficiency and uncover problems with payers. We recommend establishing metrics that can be reviewed on a consistent basis, at minimum, every 30 days. By analyzing these metrics you'll see a clearer picture of how fast you are getting paid, who's not paying, and why. With that knowledge, you're can improve processes to ensure a healthy AR.

Key RCM indicators can help you benchmark and achieve best-practice objectives:

- Monthly charges, payments, and adjustments compared to averages and historical data
- Charge-entry lag times
- Denial percentage
- Clean-claim-rate percentage
- AR aging by date of service
- Gross-collection percentage
- Net-collection percentage
- Days in AR

Calculate revenue cycle to gain valuable insight

The number of days a balance sits in AR is an important benchmark. This metric helps you understand practice cash flow and identify problem accounts. It's not difficult to calculate AR days. Simply calculate the total current receivables after credits, divided by average daily charge amount.

Know your charge-lag and processing time

Lag time refers to the period between the date of service and claim submission. Since a large part of RCM is related to days in AR, a significant lag time can negatively impact the AR-days metric.

Processing time is also important. Your practice's processing time is the period between the date of service and the date the payer pays the claim. Payer processing time is the period from patient payment receipt to provider payment.

Important AR formulas:

Net AR = ending AR – bad debt AR – unapplied

Charges per day = charges/days in month

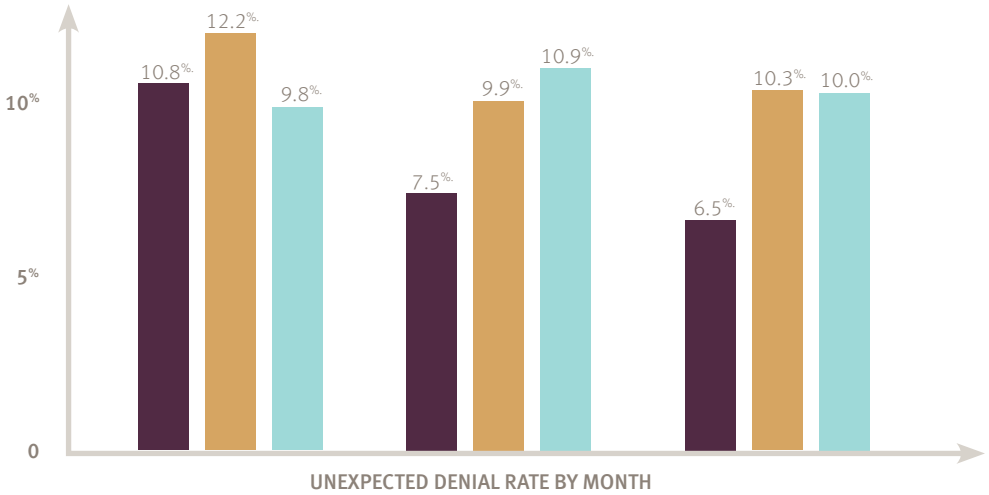
Payments per day = payments/days in month

Gross-collection % = (payments/charges) *-1

Adjusted-collection % = payments/(charges + adjustments) *-1

Compare gross and net collection ratios

The gross-collection ratio shows the amount you actually receive from what you bill. When you compare your gross-collection ratio with your net-collection ratio it can help determine whether your fees are lower than the payer allowance. You could be collecting less than what you charge due to contractual adjustments, making it more important than ever to collect all to which you are entitled. Having complete visibility into what you're collecting will reveal where you're leaving money on the table.



A sample 90-day assessment and comparison of a practice's electronic remittance advice to peer practices.

Selected

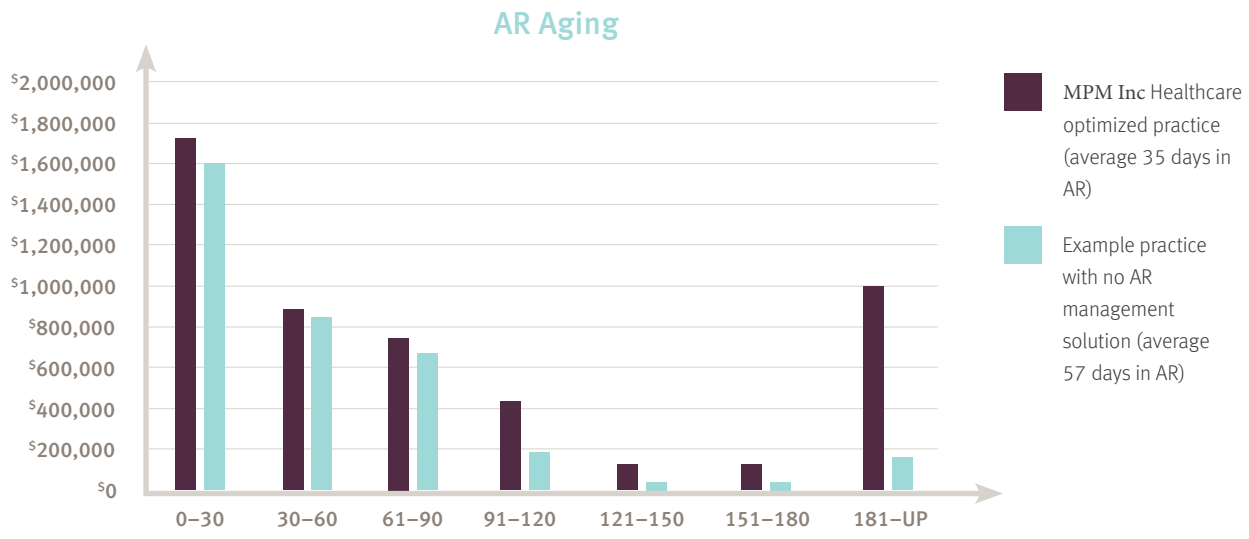
State

National

Analyze your debt's age

Everyone wants to be paid faster. A good debt-aging analysis will show you exactly how well your billing staff follows up on patient accounts and insurance claims. These reports show how long it's taking for your claims to be paid—30, 60, 90, 120 days, or more.

Example: This graph shows a practice's debt age compared to optimized AR management from MPM Inc. Healthcare, which is closer to 35 days in AR.



Automated processes can help ensure your practice has lower denial rates, and thus, improved cash flow.

Diagnose your AR health

The first-pass clean claim rate, or the rate of first-pass claim acceptance at a clearinghouse, indicates how often claims are correctly submitted the first time. The standard best practice-clean claim rate is 80%. MPM Inc. Healthcare clients average a 98% first-pass clean claims rate.

The denial rate is also an indicator of AR health. Average denial rates vary by specialty but for most, a rate of more than 10% is considered poor. Performance measured by denial rate is influenced by your payer mix, your specialty, and level.

Your clearinghouse, or a billing and collections provider, can help conduct a more in-depth denial-rate analysis by payer, provider, remark code, and category to gain an even better sense of the factors influencing your denial rate.

CHAPTER 3

CLAIMS SCRUBBING

Use best practices for cleaner claims and appeals

Even experienced billers can miss errors when reviewing claims manually. Implementing claim-scrubbing software, which identifies and fixes problem claims automatically, can save billers time, ensure greater accuracy, and generate faster error resolution.

Another best practice is to monitor the workflow to ensure protocols are followed and errors are resolved in a timely manner.

A good claim-scrubbing system can significantly reduce denials. That means accelerated and increased revenue for you.

Be sure to appeal denied claims. According to the Medical Group Management Association (MGMA), only 35% of providers do. Inspect your denied claims, ensure they are correct, and develop a denial-management process in your practice.

A MPM, Inc Office Financial Suite client can expect a 3 to 4% reduction in denials from claims submitted through their services.

Best practices

- Use claims-scrubbing technology to reduce rejections and denials
- Create a library of system edits to improve first-pass claims success
- Load CCI edits—appropriate CPT and diagnosis combinations
- Use advanced scrubbing with a payer rules engine specifying codes and modifiers for each payer
- Ensure EHRs are integrated with billing
- Ensure all payer-required fields are completed
- Leverage online reporting and analytics reporting
- Contract compliance software that catches and corrects frequent payer underpayments

CHAPTER 4

TRACK AND PREVENT DENIALS

Capture, analyze, and act on denial data

Effective denials management is about being proactive and diligent. Engaging in eligibility verification prior to a patient's visit is one front-end strategy to reduce denials. On the back end, develop a routine system for denials monitoring. Typically, 85 to 95% of claims are either paid on the first pass or prompt an action to redirect the collection to a secondary payer or the patient. The remaining 5 to 15% of claims present an opportunity to improve the revenue cycle.

It is important to regularly review which carriers, CPTs, reasons, and processes are driving your denials. It's also important to identify areas where your RCM staff may be performing redundant tasks. Review real examples of denial analysis and interventions to understand the types of edits and approaches that will help you build an experience library. This library can be used to learn from your denials and prevent them from happening again.

Denials management is not a one-and-done effort. It must be ingrained in daily, weekly, and monthly workflow. The goal is to eliminate the root cause of denials through improved workflow and technology, resulting in optimized revenue and minimized re-work. Additional recommendations for tracking and preventing denials:

- Create a mechanism to trap denials from all sources of remits, including 835 files and manual remits
- Organize denials into categories, such as:
  - Eligibility
  - Coding
  - Non-covered services
  - Authorization/Referrals
- Analyze patterns and create alternative workflows to reduce denials
- Consider bulk eligibility verification

Actions/errors that result in denied claims:

- Not verifying a patient's insurance coverage
- Entering incorrect information for the provider (name, address, contact information, etc.)
- Entering incorrect information for the patient (name, gender, date of birth, insurance ID information, etc.)
- Entering incorrect information for the insurance provider (policy number, address, contact information, etc.)
- Insufficient ICD-10 codes
- Inputting mismatched treatment and diagnostic codes
- Forgetting to input codes for services performed by a physician or another healthcare official
- Undercoding
- Duplicate billing
- Uncredentialed staff performing the service
- Missing (required) supplemental attachments or incomplete documentation for services provided
- Issues related to general knowledge and modifier use

CHAPTER 5

CREATE AND ENFORCE WRITE-OFF POLICIES

Employ the right approach to write-offs

Sound policies and procedures for write-offs are essential to running an efficient practice. Some medical practices have a formal manual to help ensure they take advantage of all available ways to increase their bottom line. To avoid unintentionally providing free services and leaving money on the table, practices need proactive financial policies. The policies should be consistently enforced and, when appropriate, shared with patients.

Contractual write-off: part of a patient's bill that can't be charged due to payer agreements, including:

- Charity write-offs (the difference between the practice fee schedule and what's collected) may be in accordance with an indigent care effort, a policy adhered to in a faith-led healthcare system, or a financial assistance program
- Small balance write-offs (the amounts left on the patient's account that may not warrant the cost of sending a bill) which have been estimated to cost about $12 each
- Prompt payment discounts and self-pay (no insurance) discounts are write-offs for patients paying in full at the time of service, or discounts given to patients without coverage

Necessary or approved write-off: write-offs that you have agreed to, either in the context of a contract, or in terms of your practice philosophy

Unnecessary write-offs: write-offs that, more often than not, can be avoided with timely filing of appeals. They are a result of billing mistakes or situations that you should have been able to control, including:

- Timely filing write-offs caused by filing the claim past the date required by the payer
- Uncredentialed provider write-offs are those caused by filing a claim for a provider before they are credentialed with the payer
- Administrative write-offs are those approved by the practice based on service issues or practice error
- Bad-debt write-offs are balances that you have decided to write off and not pursue further

Collection agency write-offs: balances not forgiven but written off the main AR and transferred to a third-party collection agency to collect on your behalf

An easy way to prevent uncredentialed write-offs is to partner with NextGen Healthcare for credentialing services.

CHAPTER 6

REMIND PATIENTS OF APPOINTMENTS

Use appointment reminders to boost AR

Ensuring as many appointment slots as possible are filled and patients are confirmed is critical to financial well-being. Appointment no-shows impact your bottom line with staff-time costs but can be reduced with an automated appointment confirmation system. HIPAA considers appointment reminders as part of treatment. They can be made without an authorization, but require you to do what you can to accommodate a patient's preferred method of communication. You can remind patients by mail, email, text, and/or phone.

In most practice management (PM) systems, this is an easy task. Most dialing systems can accept your appointment schedule from existing reports already contained in your PM system.

NextGen Office allows you to view your appointment schedule from your NextGen® Practice Management system on your laptop, iPad, or mobile device. It sends automated appointment reminders to your patients via text and/or email so they can confirm their appointments from their device.

Monitor for success

Track your cancellations and no-shows to find where improvements can be made to increase your kept appointments rate. Adjust parameters such as how far in advance your patients are contacted to see what works best.

Final recommendations:

- If not already in place, implement a policy for no-show and/or late cancellation charges to attempt to recoup lost revenue
- Utilizing staff time for patient reminders is inefficient and costly. Look to increase staff productivity while decreasing cost by implementing a third-party appointment-reminder product
- At minimum, the patient should validate:
  - Date and time
  - Location
  - Copay amount

CHAPTER 7

MAXIMIZE ELECTRONIC REMITTANCE ADVICE

Make the most of electronic remittance advices

To expedite cash flow and correct payment posting mistakes, sign up for electronic remittance advices (ERAs). Electronic claim submission maximizes the efficiency of claims processing. Paper submissions do not. About 99% of payers accept electronic claims and Medicare requires them. It takes an average of two weeks to receive reimbursement for an electronic claim if you establish an ERA, and six to eight weeks for a paper one. According to the American Medical Association (AMA), the average cost of processing a clean paper claim is $6.63. The same claim sent electronically costs only $2.90.

Electronic claims help optimize revenue cycles by streamlining the billing process and reducing paperwork. With electronic remittance, your clean claim rates and turnaround times will improve, ensuring you're paid faster.

By implementing automated PM tools and setting up auto-posting of your remittance information back into your billing system, you can reduce or eliminate many time-consuming routine tasks. This frees your staff to handle other assignments or to focus more on care.

Automate routine tasks using practice management.

Best practices

- Set the background business processor to:
  - Bill encounters nightly
  - Create your EDI files nightly
  - Print paper claims daily or have your claim clearinghouse print HCFAs
  - Create your statement file as needed: weekly, monthly, or daily

For unique claim situations, make sure you are using the claim print libraries.

BETTER STARTS HERE.

Contact us at 973-256-1998 x2 or mpm@metropm.com

4 Century Dive Suite 230
Parsippany, NJ 07054
973-256-1998 x2
www.metropm.com
mpm@metropm.com

BELIEVE IN BETTER.™

NextGen® Office