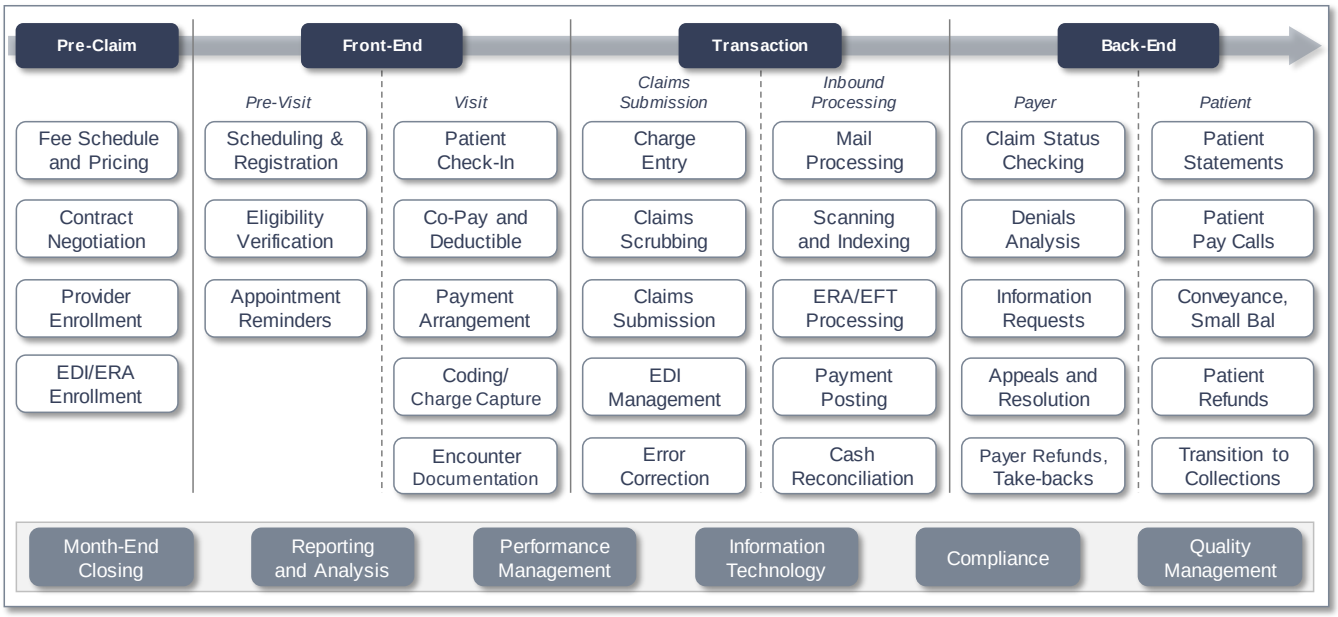
IMPROVING YOUR RCM PERFORMANCE

Whether your revenue cycle management (RCM) is done in-house or outsourced to a third party, doing the work to improve your performance is an investment that will pay off. This brief will help you do that by outlining some priority measures that you should be monitoring and identifying a few critical success factors in each step of the RCM workflow that distinguish superior performance from average results.

RCM Workflow

The RCM process is complicated, with many tasks and functions that must come together. This schematic provides one way of thinking about the very elements of the RCM process.



Key Success Factors

The key success factors for each element of the RCM workflow listed below provide a starting point for evaluating your RCM and moving your practice to a higher level of performance.

PRE-CLAIM

Fee-Schedule/Pricing	Standardize fee schedule as a common percent of Medicare to allow more consistency in ratio of payments to charges. Balance the need for your fee schedule to be higher than your reimbursement from all payers with the impact of your charges on self-pay/cash-pay patients.
Contract Negotiation	Inventory key terms of all significant commercial payer contracts. Obtain and maintain reimbursement rate for significant payers for top codes.

Provider Enrollment	Use a tracking system that provides reporting on the status of the process.
EDI/ERA Enrollment	Select EDI provider based on cost, quality of information and integration of transaction data back into the practice management system.

Front-End: Pre-Visit

Scheduling/Registration	Track demographic entry error rate and feedback to staff for process improvement.
	Communicate expectation for time of service payments.
Eligibility Verification	Leverage automated eligibility verification system.
	Develop process to confirm eligibility for non-verified patients.
Appointment Reminders	Deploy an automated reminder system to call patients in advance of their visit.

Front-End: Visit

Patient Check-In	Capture insurance card and driver's license in practice management system.
Co-Pay and Deductible	Obtain payment for co-pay and any open balance prior to visit.
Payment Arrangement	Obtain credit card and authorization to charge for patient balance due once claim is adjudicated with the payer.
	Utilize secure 'card on file' system to store and protect credit card information.
Coding/Charge Capture	Establish clear policy for timely charge entry; track open tickets, by provider.
Documentation	Establish clear policy for timely closing of charts; track and report open visits.

Transaction: Claim Submission

Charge Entry	Track and report charge entry error rate and charge entry lag (DOS to DOE).
Claim Scrubbing	Deploy claim scrubbing/edit technology to identify and stop claims with known problems before they are submitted.
Claims Submission	Track time from Date of Service to successful acceptance by payer.
EDI Management	Track and report EDI rejects (claims not accepted by the payer).
Error Correction	Track and report time to correct and re-submit rejected claims.

Transaction: Inbound Processing

Mail Processing	Process mail daily, with clear rules to route correspondence to proper person.
Scanning/Indexing	Scan/categorize all inbound paper into a document management system.

	Establish logical naming conventions for batches to make for easy retrieval.
ERA/EFT Processing	Balance and reconcile ERA transmissions and EFT deposits on a regular basis.
Payment Posting	Track and report payment posting error rate.
	Establish clear posting rules denial information is consistent across payers.
Cash Reconciliation	Balance and reconcile all payments (bank account with posted payments in practice management system) on a regular basis.

BACK-END: PAYER

Claim Status Check	Establish, for each major payer, the number of days after claims submission by which an EOB should be received and report on 'time to response.'
	Check with payers proactively on the status of unresponsive claims beyond the expected 'time to respond.'
Denials Analysis	Capture detailed denial codes/reasons on all denied claims; normalize denial reasons for consistency across payers.
	Establish, track and report target denial rate (% of CPTs denied/# of CPTs filed).
	Classify denials by major reason type and provide regular feedback to responsible parties (scheduling/registration, front desk, provider).
	Establish process to review denials and identify opportunities for improvement.
Information Requests	Track and report open 'requests for information' (data required for denial appeals) and turnaround time for providing needed information.
Appeals and Resolution	Track 'date on last worked' for open claims in the appeals process.
	Establish process to regularly review 'zero pay' (write-offs) adjustments.
Payer Take-Backs	Establish process for tracking payer refunds and take-backs in order to manage impact to cash flow and expected collections.

BACK-END: PATIENT

Patient Statements	Send statements (no more than three) on a regular and predictable schedule.
	Begin move to electronic statements (via email) to patients.
Patient Payment Calls	Establish team specifically trained to handle patient payment calls.
	Establish policy guidelines for patient payment plans that will be accepted.
Conveyance	Automate adjusting conveyances and small balance amount write-offs.
Patient Refunds	Establish regular and disciplined process to pay patient refunds due in order to

	maintain compliance with regulations.
Transition to Collections	Establish collections agency/process/approach in line with the nature of the practice and overall positioning with patients.

RCM Support Functions

Month-End Closing	Establish and follow a disciplined month-end close process that forces completion of critical tasks.
Reporting and Analysis	Provide a standard and robust monthly reporting package that trends all critical performance metrics.
	Provide a single page monthly scorecard for each provider.
	Develop an ad hoc reporting capability to allow for specific and detailed analyses to address focused questions about the RCM process or the practice performance.
Performance Mgt	Regularly review key RCM process measures to identify gaps in performance and action items for improvement.
Information Technology	Utilize a fully-functional practice management system with an open database for reporting and analytics and an easy ability to integrate third party applications.
	Integrate with the EMR for demographic and charge data exchange.
	Provide online payment option through practice website/patient portal.
	Automate simple and repetitive tasks wherever possible to reduce cost, eliminate errors, and allow staff to focus on higher value work.
Compliance	Establish and maintain a complete compliance plan and a compliance officer.
	Conduct regular reviews of provider compliance data (E&M distributions, denial rates, patient write-offs, refunds, use of modifiers, etc.) and billing documentation.
	Conduct regular provider and staff compliance training.
Quality Management	Conduct regular audits of staff performance and RCM knowledge.
	Track error rates at key steps in the process.

Managing Your Revenue Cycle: What to Watch

There are an almost untold number of measures and reports that can be used to monitor the revenue cycle. Here are the most important measures for you to track to know how well your revenue cycle is performing.

Payments	Cash is the ultimate measure of performance; track ‘payments per deposit day’ as months can range from 18-22 days, a wide variance that will impact cash. Also track ‘payments per total provider days worked’ to adjust for variations in provider time off.

Net Collection Ratio	Answers the question, 'Are we getting paid what we are contractually entitled to?' Compare Payments to Net Charges (Charges less Contractual Adjustments). Payment posting must distinguish between contractual adjustments and other adjustments.
Revenue Mix	The revenue mix evolves over time. Track these mix changes over time: ▪ % from payer v. % from patient ▪ % from office visits v. % from surgeries/procedures v. % from ancillary services ▪ % from physicians v. % from mid-level providers
Visit Volume	Visits are the headwaters of the revenue cycle. Track trends over a 13-month period (compare to same month last year). Watch the mix of visit types (new patients, established patients, surgeries/procedures, ancillary services, etc.) to get an early indicator to the future heath of the practice. Build into the key people (providers, managers) a general understanding of the average payment for each visit type.
RVU's	The most granular measure of work and productivity; tracking RVUs is particularly valuable to compare providers with different specialties. Payment per RVU provides one of the most effective payer-to-payer reimbursement comparisons.
Days in AR	An important measure, but easily distorted (e.g. just writing off denials will reduce days in AR). Track how aging buckets resolve over time; pay particular attention to the 'old' bucket (varies by specialty – some track 90+ days; some 120+ days).
First Pay Rate	Measures percentage of claims paid in full by the payer on the first EOB (no denial); adjust for balances rolled to the patient. Higher is better for faster cash flow, lower cost (working denials costs money), and less likelihood of losing a payment entirely.
Denial Rate	Number of CPTs denied as a percentage of the total CPTs submitted (denials occur at the CPT, not the claim level). While some level of denials is inevitable, a high denial rate (target varies by specialty) indicates where the process (front end demographics, back end coding) is not working as it should. Few things better drive RCM performance improvement than a good denials management process.
Zero Pay %	All claims that receive no payment before they are completely adjusted to a zero balance. Some of these may make sense, but a zero pay claim generally means work was done for free.

A Word of Caution	When considering any RCM data, there are two things you should always know: ▪ Is the information reported on a 'Date of Service' (date of the visit) or 'Date of Entry' (date the claim was entered) basis? This may not seem like a distinction that matters much, but it does, particularly since DOS data continues to move over time as claims are processed. ▪ Is the information reported for all claims or only closed claims (zero balance)? In neither case is one or the other always 'right.' Different measures are best served by one or the other and some measures just don't make sense if the data are defined the wrong way. Know which is best for the question you are trying to answer and know how the data you are reviewing are defined.

AN RCM PARTNERSHIP WITH ALN

For over 18 years, ALN has provided outsourced revenue cycle management services to independent physician practices across the country. With millions of claims processed across most clinical specialties, our team has the expertise to help our clients realize significant improvement in their revenue cycle. We have the size and scale to deliver high level results but are small enough to custom configure our solution for each client based on the unique needs of their practice.

For a discussion about how we might be able to help, visit www.alnmm.com or contact randy@alnmm.com.