Revenue Cycle

The Big Question

Far and away, the number one and overriding question for physician practices when it comes to their revenue cycle is:

‘How are we getting paid compared to how we should be getting paid?’

The question seems straightforward, but the answer is complex. This white paper will explain what goes into that question and give you a framework against which you can assess your current revenue cycle.

REVENUE CYCLE MANAGEMENT: THE BIG QUESTION

THE COMPLEXITIES OF REVENUE CYCLE MANAGEMENT (RCM)

The revenue cycle for your practice is one of the most important processes in your business. Obviously, it converts your work into cash, but it is more than that. It plays a key role in your patient experience and satisfaction, it fulfills a critical element of your compliance, and it captures some of the most valuable information that you need to run your business.

RCM used to be thought of as just billing, but now a more robust understanding of RCM encompasses all the above, plus managed care contracting, coding, value-based reimbursement arrangements, the key integration with your EMR and clinical operations, and an ever-expanding reporting and analytics function.

While acknowledging the broad scope of today's revenue cycle, this paper focuses specifically on the central RCM question in the still predominant fee-for-service model: 'How are we getting paid compared to how we should be getting paid?'

There are three separate, but related, parts to the answer:

- Amount Paid: How does the amount paid compare to what should have been paid per the contract?
- Time to Pay: How long does it take to get full payment?
- Effort to Resolve: How much work is required to get paid as we should?

Properly answering these questions will involve understanding payer contracts, denials, adjustments, patient pay, and several other concepts. We will now take the three parts in turn.

> *Note: This paper addresses claims for which the practice has a contract with the payer. It does not apply to out-of-network and non-participating claims.*

1. DID WE GET PAID WHAT WE SHOULD HAVE?

This is the most important part of the big question, the first thing that physicians and administrators have in mind around their RCM process. Simply put, the real question is whether payers – commercial or government - are paying the correct amount, per the negotiated contact. This is known as the **Allowed Amount**, the total amount the payer says is due to your practice after the payer reprices the claim according to the contract. The Allowed Amount has to be compared to the **Expected Amount**, what the practice believes is due.

But before you can know either the Expected or the Allowed Amounts, you must first work through the Denials and Adjustments.

Denials and Adjustments

The final Allowed Amount and the Expected Amount cannot be properly determined until all **Denials**, the various adjudication rulings issued by the payer on each claim, are worked to completion. How Denials are managed is one of the primary differentiations between high and low performing RCM operations.

Denials, which occur at the CPT and not the claim level, are, at least initially, a **Zero Paid CPT** that, unless worked and reversed, would result in an **Adjustment**, a write-off of the charges for that CPT code. Unless resubmitted or appealed, the payer will assume their initial Denial is correct and the end of the story. However, practices should consider Denials are just a potential delay in processing/payment until you have concluded otherwise.

Not all Denials are a failure of the payer to pay according to the contract. Generally, Denials can be categorized into three broad types:

- Proper: Some Denials are the correct interpretation of the contract and, accordingly, those CPT codes should not be paid, and multiple appeals will not change that determination. These codes may be for services that are bundled into other services or excluded from contract coverage.

  The difficult to accept Denials are those that are correct, but occurred because of some internal failure in the RCM process (see box at right). More than almost anything else, the rate at which these types of Denials occur and the processes in place to identify and rectify them is the primary indicator of the performance level of your RCM process.

  Proper Denials are then posted as an Adjustment and written off.

- Requests for Additional Information: Many Denials are really a request for more, or corrected, information. For example, if the patient provided incorrect demographic or insurance information, the payer is not able to properly adjudicate the claim and will deny all CPT codes on the claim. Once the correct information is resubmitted, the claim should be reprocessed.

Types of Denials that Reflect Some Level of Failure in the RCM Process

- No pre-authorization
- No referral
- Service covered in global period
- Maximum frequency exceeded
- Timely filing
- Provider not credentialed
- Missing necessary documentation

- Disagreements in Interpretation: For this type of Denial, the practice has points of legitimate disagreement with the payer and these should be appealed. Denials for medical necessity are the most common example here. If the appeal process is not successful, eventually these Denials will also become Adjustments and written off.

The Expected Amount

The **Expected Amount** is what the practice believes should be paid on any given claim. However, determining this is complex. It is often assumed that simply 'loading the contracts into the billing system' is all that is required to determine the amount that should be paid, but that simplistic calculation will lead to many false negatives that will overstate underpayment by payers, create unnecessary work, and add to physician angst.

For example, if you take a claim with two CPT codes and simply add the contracted rate for both codes and assume that is the Expected Amount without considering how the second CPT might be bundled with the first or discounted for multiple procedures, your Expected Amount will be inaccurate.

Calculating the Expected Amount requires considering the following factors:

- Contract Rate: The contract with each payer is the starting point for adjusting the charges to calculate the Expected Amount. This is often expressed as a multiple of the Medicare rates (e.g. 120% of Medicare), but there are always nuances beyond the headline number.

  First, if the contract directly prices as a multiple of Medicare, it must be determined which Medicare year is used and how the contract changes as Medicare changes over the life of the contract. For example, Medicare changes what it pays on some items as frequently as once a quarter and commercial contract tied to Medicare may do the same.

  Second, some CPTs may be carved out from the base model and priced differently. This is common on certain medications and equipment codes.

  If that is not complicated enough, there is a very arcane piece in how Medicare, and thus all commercial contract tied to Medicare, adjusts prices based on geography. This is the Geographic Practice Cost Index (GPCI, pronounced 'gypsy') and it adjusts the Medicare rate by region. Many practices operate in what they believe is a single market, but actually span mutliple GPCIs and thus get multiple 'correct'amounts from Medicare on the same CPT code. Unless your calculated Expected Amount has the right GPCI, it will be wrong.

As such, RCM best practice requires that you not only have up-to-date contracts, but also the associated **Plan Fee Schedules** that detail out the amount to be paid for each CPT code at the individual plan, not insurance company, level.

It should be noted that the process of maintaining contracts and Plan Fee Schedules is no small task, so it is generally best to concentrate on maintaining contracts and Plan Fee Schedules on the top plans for the most frequently used CPT codes. Covering 80% or more of your claim volume is generally sufficient and provides the right return on the investment required.

- Correct Plan Selection: When we speak of payers, we often think in terms of the insurance company, but generally a practice will participate with multiple plans offered by the same carrier. These plans do not necessarily carry the same Plan Fee Schedules or contract rules. To accurately determine what should be paid, the correct plan for the patient must be associated with the claim. This requires your practice management system to be configured with this level of detail and your staff to capture this correctly at registration.
- Payer/Plan Processing Rules: Depending on the specific plan, certain adjustments from what is coded on the claim are allowed by the contract. These adjustments are required to accurately determine what should be paid.

  For example, a plan might disallow certain codes because they require those services to be delivered by an exclusive provider. Or, they may bundle certain codes or exclude others.

  The contract will also have rules dictating how charges will be adjusted for modifiers, multiple CPT codes, site of service adjustments, and other considerations.

  In addition to the base **Contractual Adjustments,** the overall discount applied to reprice each CPT code per the contact, these adjustments must also be applied to get to an accurate calculation of the Expected Amount.

The Allowed Amount

If the Expected Amount is what the practice believes should be paid, the Allowed Amount is what the payer determines should be paid on any given claim. As discussed above, the Allowed Amount cannot be determined until the **Insurance Balance** (amount to be paid by the payer and not the patient) for all CPTs codes on the claim is zero (all corrections and resubmissions have been done, all appeals have been exhausted, all payer payments have been made, all Adjustments posted, and the portion of the Allowed Amount to be paid by the patient transferred to patient responsibility, leaving the Insurance Balance at zero).

Note that the Allowed Amount is not necessarily the amount the practice will get paid, but just the payer's determination of what the claim should pay. As we will see below, the actual paid amount also depends on collecting from the patient.

Getting to Zero Insurance Balance

Charges

less Contractual Adjustments

less Payer Payments

less Balance Transfer to Patients

Zero Insurance Balance

Comparing Expected to Allowed Amounts

This gets to the heart of the big question and doing this comparison on a regular basis is clearly the best practice, but it requires substantial operational discipline to produce reliable results. Given the complexity of this exercise, it is generally best done in a batch process, typically once a month, and applied to variance amounts above a certain threshold. This process is best managed through analytics and reporting as opposed to the individual claim level.

Operational Requirements

To do this analysis correctly and repeatedly, month after month, requires the following operational capabilities and disciplines:

- A system, inside or outside the practice management system, that can properly handle the various repricing adjustments discussed above.
- Having, and maintaining, correct and current contracts and Plan Fee Schedules.
- Assigning the patient to the correct plan (not just carrier) at the time of registration.
- Proper and consistent EOB posting so that Denials and Adjustments are categorized properly.
- Understanding and applying payer/plan processing rules that modify the claim beyond just the contracted rate.

Comparison Analysis

Once you can compare accurate Expected Amounts with the Allowed Amounts, at the CPT level, there are one of three possible outcomes:

- **Correctly Paid CPTs**: The payer paid correctly, per the contract.
- **Zero Paid CPTs**: The payer paid nothing on the CPT and it was adjusted off entirely. As discussed, these Zero Paid CPTs may be accurate or there may be a disagreement with the payer.
- **Underpaid CPTs**: The payer paid some amount on the CPT code, but less than the practice believes is due per the terms of the contract.

Underpayment Appeals

While denied claims should be appealed individually on an ongoing basis, a robust process for comparing the Allowed Amount to the practice's own calculation of the Expected Amount provides a basis for additional appeals to the payer. This may come at the individual claim level (i.e. these CPTs on this claim were underpaid) or as a mass appeal to the provider representative of the payer (i.e. these claims were all underpaid in the same way).

This process is particularly important at the beginning of a new or renegotiated contract to ensure the payer properly loaded the contract rates and terms into their adjudication system.

The Paid Amount

The Allowed Amount, however, is only part of the answer to the question of whether the practice got paid what it should have. This is the total amount that the payer says should be paid for the claim, the maximum allowable, but some of that amount will be paid by the payer and some of that responsibility may be transferred to the patient. With the continual increase in co-pays and deductibles, this is now very material for most practices. Thus, to fully answer the first question, the analysis must calculate the final **Paid Amount** (payer + patient), as a percentage of the Allowed Amount.

Fortunately, determining the Paid Amount is much easier, but requires a 'closed claim' analysis. A claim is considered closed when the total balance is zero. Best practice reimbursement analysis involves periodically comparing, by payer and even plan, the Paid Amount against the Allowed Amount.

At times, practices may find a payer that does reasonably well matching the Allowed Amount to the contract and the rate might compare favorably to other payers, but if a significant portion of the Allowed Amount is shifted to patient responsibility and the particular patient demographic does not pay well, there will be a resulting material shrinkage between the Allowed Amount and the Paid Amount.

The Opportunity

The single most important measure of your RCM process rests on this question – how well did we get paid? How close was the payer's Allowed Amount to your Expected Amount? And of the Expected Amount, how much was actually collected (known as the **Net Collection Ratio**).

Here, there is significant variation between high and low performing RCM operations. MGMA reports the average practice collects between 92-94% of what is due, while many practices are worse than this benchmark. By contrast, high performance RCM will collect between 98-99%, a gain that has significant financial benefits for the practice.

The example below demonstrates how improving RCM performance by 5% (93% to 98%) could increase physician compensation by almost 12% because the overhead does not change and the improvement in payments flows through to the provider.

Impact of Improved Net Collections Ratio		
Net Collection Ratio	93%	98%
Charges	1,300,000	1,300,000
Proper Adjustments	(700,000)	(700,000)
Allowed Amount	600,000	600,000
Paid Amount	**558,000**	**588,000**
Increase in Payments	**N/A**	**30,000**
Overhead	300,000	300,000
Physician Comp (after Overhead)	258,000	288,000
Increase in Physician Comp	N/A	12%

2. How Long Did It Take Us To Get Paid?

The second part of assessing how well you got paid compared to how you should have is about time, the duration between when the service was delivered and when the claim was finally fully resolved (zero balance).

The most expansive time measure calculates the date from when the claim was originally submitted to when the final balance reaches zero. This considers the time to resolve the patient pay responsibility and, thus, is very dependent on how quickly your practice works and resolves patient AR.

When evaluating the payers, it is more helpful to consider how long from the date of original successful submission until the insurance balance reaches zero. This factors in how many denials are received and how quickly these are being reprocessed to resolution. It is important to note that this measure is not only impacted by how quickly payers process claims and denials, but also how fast they are processed by your organization.

Other time-related measures that are helpful include:

- Date of Service to Date of Entry Delay: This indicates how quickly claims are getting out of the practice and to the payer for processing.
- Time to First Response: This measures how long it takes the payer, once a claim is received, to provide the first EOB back to the practice.
- Time to Subsequent Responses: Once a claim is in the denial/appeal/response process, there is significant variation in how the sub-processes operate but tracking how quickly your internal team and payers are moving these through the appeals process is important.

3. How Hard Was It to Get Paid?

The final aspect of the big RCM question is about effort and the level of work required to get claims fully resolved. While this will lead to a more ambiguous answer, there are some tangible measures that illuminate how hard it is to get paid from particular payers. Some of these include:

- Denial Rate: If the **Denial Rate**, the percentage of CPTs that are denied, is materially higher than for other payers, more effort will be required to get paid.
- Rate of Clinical Opinion Denials: Denials around matters of clinical opinion, mostly medical necessity, take more time than simple resubmissions with corrected demographic information and these appeals often require time from your providers. Payers with higher than average clinical opinion denials create more work for the practice.
- Appeal Win Rate: When the practice elects to appeal a Denial because you disagree with the payer's initial opinion, you incur time and cost. Appeals are often the single most expensive activity in the RCM process, so you want these efforts to be rewarded with an appropriate level of reversal and payment by the payer. How frequently the payer changes their opinion on denials is a helpful measure.

The Right RCM Infrastructure

As with any complex operation, high performance requires having the right people, processes, information and technology working in concert. The RCM process is no different. When these come together, the Big Question is answered the way everyone wants – yes, we got paid as we should.

- People: Previously, billing was done by a 'biller,' a person who essentially managed the entire process from beginning to end. The dramatic increase in complexity of the process, the compliance demands, and the underlying technology that supports RCM means that is no longer possible. A wide range of skill sets and domain knowledge is required to deliver top level RCM results.
- Process: As this paper outlines for just part of the revenue cycle, there are many processes that must come together in a reliable, consistent and disciplined way to produce optimal results. These processes are not limited to the Billing Department but require significant participation by both providers and clinic operations staff. Intentional design and disciplined execution – database set-up, contract fee schedule management, patient registration, coding and charge capture, adjustment classification and posting, denials management, arranging for patient payment – is required across the entire revenue cycle or performance will degrade over time.
- Information: Without question, the 'Management' part of RCM, the oversight of the Revenue Cycle, relies on an extensive amount of complex information. Attempting to operate a high-performance revenue cycle relying on individual claim anecdotes or the staff's 'sense of things' will not work. Physicians, practice administrators, and managers of the revenue cycle who support them must have, and be comfortable using, the types of complex information outlined in this paper.
- Technology: All three – people, process, information – must operate on an increasingly sophisticated technology platform. This is no longer about the 'billing system,' the claims processing application. The practice management system is the foundation of a practice's IT infrastructure, particularly the revenue cycle. The RCM system must integrate closely with the EMR, leverage advances in EDI and data sharing with outside organizations and have a robust data structure that allows for the level of reporting and analytics necessary to manage the RCM process.

WHY CONSIDER RCM OUTSOURCING

Previously, the decision to keep RCM in-house or outsource hinged on just a few issues:

- Control: Practices perceived that in-house operations gave them more control.
- Staffing: Whether the practice could find, and was willing to manage, the billing staff was often a key consideration.
- Cost: Performance variations were perceived to be small between high and low RCM performance, so the economic decision was simply a comparison of in-house costs vs. outsourcing fees.

With the changes in the industry, the decision matrix for a practice has expanded and the case for outsourcing to the right partner has grown and now includes the following considerations:

- Control and transparency: With the complexity of the RCM process, real control is no longer achieved by simply having the staff down the hall on your payroll, but by having processes that are measured, reported, tracked and managed as outlined in this paper. Outsourcing providers can invest in these capabilities in ways that in-house billing operations cannot.
- Full effort: A common concern about outsourcing is whether the service provider will work as hard as in-house staff to collect on difficult claims. Setting aside the questionable assumption that employed staff are more motivated than an outsourcer, as this paper outlines, a fully measured and transparent process is the best assurance for getting the right level of effort on hard to collect claims.
- Talent: The RCM process now requires so many skill sets that even practices with a fairly large number of providers cannot have all the necessary people on staff. Additionally, in low unemployment environments, it is hard for many practices to find and retain qualified RCM employees without their wages escalating too quickly.
- Compliance: The compliance risks – both billing and data security – for a practice related to its revenue cycle are simply too great to ignore. Many practices cannot make the investment required to properly manage those risks, but outsourcing providers are able to spread the costs of compliance investments across multiple clients.
- Technology: Likewise, the number of technologies required to support the revenue cycle grows every year. The capital, operating expense and talent required to build and support these technologies give the outsourcer the advantage of scale that is passed on to the practice, something that cannot be done if the RCM is kept in house.
- Management focus: Most administrators are now trying to navigate the practice through the ever-changing healthcare landscape and find they just have more on their plate than they can manage. Major strategic initiatives such as growth, health system relationships, and dealing with new competitive threats must take priority, along with the day to day rhythm of managing their physicians, staff and clinic operations. Allowing a trusted partner to manage their RCM and the technology that goes with it allows them to focus on what matters most.
- Economics beyond cost: While the cost of outsourcing still is an important factor, there are other economic considerations as well. As outlined in this paper, there are significant differences in collections and cash performance that dwarf small differences in RCM cost. As the revenue cycle becomes more and more automated, the outsourcer invests their capital to build capabilities, allowing the practice to use its capital elsewhere.

SO, NOW WHAT?

Yes, this is complex, but if your revenue cycle management is not able to perform at this level, you are likely leaving money on the table. If you are not able to quickly get your current RCM team and process to this standard, consider outsourcing with ALN. Our processes conform to what is described in this paper.

GLOSSARY

Adjustment: The write-off of the charges for a Zero Pay CPT.

Allowed Amount: The total amount the payer says is due to the practice after the payer reprices the claim according to the contract.

Contractual Adjustments: The various discounts applied by the payer to reprice each CPT code.

Correctly Paid CPTs: CPTs repriced by the payer paid correctly, per the contract

Denials: The various adjudication rulings by the payer on each claim.

Denial Rate: The number of CPTs denied by the payer, as a percentage of the CPTs submitted.

Expected Amount: What the practice believes should be paid on any given claim according to the contract.

Insurance Balance: Amount to be paid by the payer, not the patient

Net Collection Ratio: The Paid Amount as a percentage of the Expected Amount.

Paid Amount: The actual amount paid on a claim by the payer and the patient

Plan Fee Schedules: Detail tables that specify the amount to be paid for each CPT code according to the contract, at the individual plan, not insurance company, level.

Underpaid CPTs: CPTs where the payer paid some amount, but less than the practice believes is due per the terms of the contract.

Zero Paid CPT: CPTs that the payer determines are not eligible for any payment.