REVENUE CYCLE MANAGEMENT – IT'S MORE THAN YOU THINK

By Jeff Gorke, Senior Vice President | Coker Group

Revenue is the lifeblood of any business. Businesses cannot thrive nor survive, regardless of their market segment or service line, without cash in the door. Whether privately held or publicly financed (e.g., stocks/equity; bonds), the inflow of revenue and efficient revenue cycle management (RCM) precede the viability of any business.

Given the margins in healthcare, this factor is no less true in the operation of ambulatory physicians (or private practices) employed by health systems. Stunningly, some institutions and practices continue to under-invest or "back burner" the significance of revenue cycle management and its accompanying component pieces.

With that in mind, accurate billing and revenue management, from A to Z, is more acute for a physician enterprise than for your local 7-11 convenience store. Processes as delineated below are requisite. To complicate matters, and as the healthcare industry continues to shift from fee-for-service to fee-for-value, reimbursement methodologies (including MACRA/MIPs and APMs) will further stress and strain RCM systems.

So, is your RCM backbone ready and able to administer these matters to ensure good data, sound billing, and accurate and timely follow-up? Now is the time to review your baseline and your capability for both traditional and global reimbursement models.

It Begins Like This

Too often the RCM is viewed in pieces vs. as a system with multiple inputs and variables, as Figure 1 illustrates.

Figure 1. Unstructured RCM

For instance, whether a private practice or health system, provider hiring, onboarding, and credentialing are often fragmented leading to lost revenues and avoidable and unnecessary payment delays. By way of example, Coker had a client that simply hired new physicians and added them to the network while essentially regarding credentialing as an afterthought (i.e., less than systematically). Thus, the system had physicians who were on staff with privileges in the hospital who were not credentialed with payers. This scenario lasted, with some payers *for more than a year.* That said, coordination of hiring and credentialing of providers is essential to the smooth operation of an RCM.

Next, clinics often forget that the RCM process begins *before the point of care* when the patient is scheduled, with a thorough review of eligibility. Then, when the patient arrives for their visit, staff must collect copays, deductible, and/or any cash balances outstanding. This component is predicated on the billing staff, whether in a central billing office (CBO) or the back of the clinic, delivering a daily listing of expected patient visits along with their financial obligation, whether current (e.g., the day's visit) or outstanding balances. The front desk team should have delineated policies and procedures (P&P) in place to provide consistency of action at the front desk and during the check-in process. The list should include all necessary paperwork and ensure a deeper dive than querying about changes in patient insurance coverage, etc. (The question should *never* be "….do you still have the same insurance…."?)

The Process Continues

Then, post visit, documentation, charge capture, and coding of the visit should occur as soon as is practicable. Providers must perform all of their charge capture and coding and documentation education and reviews to ensure accurate reimbursement.

After the claim submission, follow-up is key from a timing and cash flow perspective. Avoidable denials (e.g., forgotten advanced beneficiary notices [ABN], Medicare secondary payer [MSP] forms, etc.) provide education opportunities to managers. These and other denials, should be managed and tracked to baseline and ensure that staff education has positively impacted (e.g., reduced) the denial rate. Also, tracking by payer can help managers uncover denial "trends" of payers to determine if a particular code is routinely denied and/or bundled. With our client mentioned above, feedback and errors were handled haphazardly with little education and/or corrective action taken. No policies or procedures were in place to manage the educational flow of information, training, or criteria for staff remediation apropos of their annual evaluations. Historically, This client had given little focus to patients who did not pay after three–four months; few accounts were ever turned over to collections, and managers from the CBO on down to the office managers offered almost no feedback regarding coding errors, diagnostic code errors, etc. As expected, similar errors continued to arise.

Concurrently, the billing staff should manage by report. Detailed reporting on days in accounts receivable, aging buckets, and adjustments/write-offs will empower managers to assess both the RCM and the staff objectively.

Lastly, the clinics should have a collections policy that delineates when and how patients with outstanding and aged balances will be both treated and submitted to collections.

So, let's presume that your entire RCM currently functions well, as you've defined "well." You'd be one of the few. Many health systems and practices struggle with at least some component of their RCM processes and procedures. Toss on that the continuing shift in how providers will receive reimbursements and an entirely new angle is injected into the RCM process.

In fact, many systems that believe their approach to RCM is fundamentally and financially sound may find that MACRA/MIPS and bundled payment methodologies will render their processes outdated in the context of fee-for-value and bundled payment reimbursements. Most healthcare organizations exist in an era of generic charge capture and claims processing without any visibility and tracking of quality or performance. That is, a level three recheck is performed, it is billed out, the electronic fund transfer (EFT) returns, and the payment is posted to the patient's account. That scenario is predictable if everything goes along smoothly, i.e., no denials, no rejections, etc.

Regardless of the fate of the Affordable Care Act, the push will continue to move away from volume (e.g., more patients) toward value. Reimbursements will be based on the quality of care, repeatable outcomes, and value delivered by providers than on how many level three rechecks a facility can manage during a clinic on a given day. To function under that new paradigm, information technology (IT) systems (inclusive and exclusive of RCM) and processes will need to evolve and adapt to these new payment models.

RCM systems will need to change to manage the charging and collecting piece of their revenue, in the near term, via a "normal" RCM and be able to handle and parse out bundled payments. For instance, Figure 2 shows the current status of the fee-for-service revenue cycle.

Figure 2. Fee-for-Service Revenue Cycle

Old RCM*	Charged	Adjustment	Allowed	Paid	AR
99213	$ 225	$ (75)	$ 150	$ 100	$ 50
99214	$ 275	$ (90)	$ 185	$ 100	$ 85
99215	$ 300	$ (100)	$ 200	$ 100	$ 100
Totals:	$ 800	$ (265)	$ 535	$ 300	$ 235

If you are billing a fair number of E&M codes and the process is working smoothly, you will know precisely how much revenue is outstanding. We suggest, though, that a majority of practices and hospital systems struggle to manage their accounts receivable (AR), even under the "current" model.

However, let us look into a crystal ball and ponder a bundled payment in addition to our current RCM (see Figure 2, above). (Note: this article does not consider how to manage the delivery of care so as to save money and increase margins on the bundled payment.)

In Figure 3, we contemplate a Medicare Model Four Bundled Payments for Care Improvement (BPCI) imitative. Let us assume that this is for orthopedic surgery X. You can see that the BPCI bundle includes a pre-op visit, procedure 1 (in surgery), procedure 2 (in surgery), post-op, and durable medical equipment (DME).

Figure 3. BPCI Example

CMS Model 4 Bundled Payments for Care Improvement (BPCI)		
Care Group (w/System) - Ortho Surg X	Units	
Pre-Op	1	
Procedure 1	1	
Procedure 2	1	
Post-op	1	
DME 1	1	
Global Reimbursement:		$ 10,000

This BPCI involves multiple parties: The hospital where the surgery will be performed; the physicians' surgery procedures; and DME for our post-op patient. The prospective value of this bundle is $10,000. (By the way, if the procedure costs more than $10,000 to perform, the parties are in the red.) Leaving aside the practice's need to manage its costs to ensure that its piece of the $10,000 provides profit, the hospital is the "Awardee" in this instance. That is, the bundle goes to the Awardee. That said, how will you ensure that the practice receives appropriate remuneration for its portion of the bundled payment? Additionally, how do you set that "allowable" in your PM system? Here, the tricky component is in understanding your bundles, how to manage both the fee-for-service aspects and the bundled component, and how those will affect the practice's finances. Enhanced data analysis and reporting will be necessary. Will you intuit the components of what the practice is "liable" for under these new schemes and understand the status of the revenues and the RCM completely?

Conclusion

To ensure a streamlined RCM, you must

- Understand, and communicate with staff all of the steps and components involved in the RCM process. (An "ecosystem" approach ensures that staff understands the necessity of every piece of the RCM.)
- As necessary, realign staff to ensure the right person is in the right job; ensure that "job function" is clearly elucidated.
- Consolidate, where possible, disparate processes that occur throughout the organization.
- Establish reporting structures and consistent lines of communication.
- Provide feedback to the practice(s) so that avoidable denials and errors created at the practice level improve; this also places some of the onus of repairs on those who've submitted erroneous work.
- Design, develop, and implement P&Ps for the clinic or CBO.
- Improve front office (e.g., check-in) collections of co-pays and deductibles; baseline and budget.
- Measure, monitor, communicate, alter/adjust (the RCM) as needed.
- Prepare for bundled payment methodologies and handling of same.
- Consider status of IT system to handle bundles.
- Where possible, automate processes for efficiencies (e.g., payment posting)

Please share your thoughts about Revenue Cycle Management and any questions you may have about how Coker Group can help your organization by contacting Jeff Gorke, Senior Vice President at jgorke@cokergroup.com or by calling 678-832-2021.