



Revenue Cycle Management, A to Z

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You probably think of it as billing and collections, but today, the whole process of maximizing your revenues from patient care is known as “revenue cycle management” (RCM). This process encompasses everything from checking eligibility and collecting copays to charge coding, bill preparation, data entry, claims submission, payment posting, and managing accounts receivable.

To do all of this correctly requires a thorough knowledge of payer rules and procedures. Your office must also continually improve its billing and collections processes. And, to get the reports you need to do that, it’s essential to have an up-to-date, sophisticated practice management (PM) system. So it’s not surprising that many practices have outsourced their RCM to billing services, specialized RCM companies, or management services organizations (MSOs). If you’re considering a similar move, ask yourself some simple questions: Could you do RCM just as well internally? If so, would you come out ahead financially?

This white paper will help you answer these questions for your own practice by explaining the key elements of RCM (Figure 1) and the circumstances in which it might make sense to outsource this vital part of your financial operations. In addition, we’ll look at the various types of outsourcers, comparing their pros and cons for physician practices.

DOING IT YOURSELF

About 80 percent of physicians handle their own RCM, and some consultants say that’s the way to go in most cases — even if a practice has been poorly run. “Unless there are some atypical factors, usually the practice can straighten itself out and do as well as an outsourcing firm could,” says Gary Matthews, an Atlanta-based practice management consultant.

Caveats abound, however. To do RCM effectively in-house, you have to examine your people, processes, and systems, notes Terri Fischer, revenue cycle manager for the LarsonAllen Health Care Group, a St. Louis consulting firm. It’s a real challenge to find the right people for your business office, especially in smaller communities, she says. “The amount of knowledge and skill they need has grown by leaps and bounds, particularly in specialty fields.” Also, she points out, superb billers are self-directed people. Smaller practices usually can’t afford to

pay them large salaries, but they must nevertheless take pride in their work to be good at what they do.

Internal processes should emphasize efficiency and must be constantly upgraded. “How we do it and how we’re paid is constantly changing,” says Fischer. If you’re using the same processes you did 10 years ago, your RCM isn’t up to par.

Similarly, a state-of-the-art PM system is essential. Process improvement depends partly on having software that can pick up problems before claims are sent out and that enables you to run reports showing where the errors occur. Many older systems are “just billing systems,” Fischer says. “They have no management or reporting functions. You can’t extract the data that will help you improve.”

It’s rare these days for practices not to have a billing system, consultants say. Offices that still mail paper claims to payers or a billing service are probably in trouble. As with everything else in healthcare, this rule has exceptions.

The Building Blocks

To effectively handle RCM in-house, practices must pay attention to:

- ▼ Eligibility determination
- ▼ Copay collection
- ▼ Coding
- ▼ Bill submission
- ▼ Bill tracking and posting
- ▼ A/R management
- ▼ Reporting and benchmarking

Eligibility determination. It’s more important than ever to check on the insurance eligibility of every patient. Patients switch plans more often than they used to, and they’re bearing more of the cost of healthcare in general.

“In this day and age, when patient balances are growing because of higher copays and coinsurance, it’s imperative that we focus on patient balances,” Fischer notes. “For 20 years, we had a generation that wasn’t responsible for the cost of their care, because of HMOs and PPOs, and now they are. We need to refocus in that area, because we’ve neglected it. It wasn’t a big part of the A/R before, but it’s becoming a huge part of A/R for many practices.”

There are many ways to check eligibility, but the old-fashioned method of going through health-plan rosters

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line by line is labor-intensive, and the lists are often inaccurate. Calling the plan on the phone usually takes too much time, unless a voice-response system is available. Many plans now allow practices to check eligibility online, and some enable them to do that with swipe-card terminals. Insurers such as UnitedHealthcare and Humana also offer “real-time claims adjudication,” so your staff can instantly find out what the patient owes out-of-pocket before he leaves your office.

If possible, have staff determine patients’ benefits before they visit. At a minimum, front-desk personnel should photocopy patients’ insurance cards.

Copay collection. Staff should ascertain a patient’s copayment when checking her eligibility — the amount on the insurance card isn’t always correct.

Staff should also try to collect the copay before the patient leaves. Otherwise, you could spend more on collecting the copay than you receive. And those copays can add up: If your average patient has a \$20 copay and you see 30 patients a day, that’s \$600; plenty of no-frills plans now require much higher copay and deductible levels.

Also, check the patient’s balance before he heads for the door. Surgical practices might want to collect coinsurance or remaining deductible amounts upfront, notes Cindy Dunn, a Medical Group Management Association (MGMA) consultant in Boca Raton, Fla.

Coding. There are two schools of thought on coding: Some consultants recommend that physicians do it, and others say that a billing person can handle it, using boxes checked off on a superbill. Most experts agree, however, that every practice should employ at least one certified coder. Even if you do your own coding, it’s important to

have a specialist look over claims to make sure that all charges are captured and nothing that might catch an auditor’s eye goes out. “You have to make sure you capture the correct coding and all the services that you render,” says Fischer. “A lot of offices lose money because they’re not capturing everything consistently.”

In some specialties, it’s not possible for physicians to code charges themselves. For example, a large group of emergency physicians in Seattle sends transcribed dictation to a billing service, where specially trained billers pick the proper codes and enter the claims. The ER docs are just too busy, and see too many different kinds of cases, to do their own coding.

Bill submission. To minimize costs and maximize returns from bill submission, practices should emphasize efficiency, reliability, and the ability to learn from mistakes. For example, the people inputting data may be billers, data-entry clerks, or front-desk staff grabbing time between other tasks. But if someone gets it wrong, you could be in a world of trouble. “Especially if you have a new person, you have to watch that person’s performance,” notes Matthews. “If she’s entering claims data for 15 percent of your business and her error rate is 5 percent, you’ll get buried.”

Sophisticated billing systems include “scrubbers” that spot obvious problems in claims, such as information in the wrong fields or a conflict between the diagnosis and procedure codes. Some practices still encounter high denial rates, even with scrubbers, so billing supervisors should keep a close eye on claims preparation.

Also, get your claims out as soon as possible. While this might seem obvious, some practices submit claims weekly or even monthly. Fischer recommends that all claims be transmitted within 48 hours — and preferably within 24 hours.

Bill tracking and posting. Your PM system keeps track of which claims haven’t been paid, but the first step in collections is to find out why they haven’t been paid. This requires experienced billers who’ve established relationships at the health plans and can punch through what often seem to be plans’ walls of obfuscation. Again, some carriers provide online data about claims status.

When claims are kicked back by your billing system or clearinghouse, it’s important to look at why and try to avoid repeating the error. In busy offices, staff often fix problems in individual claims and send them back out without mentioning it to anyone else.

Many practices also miss a major opportunity for education when staff post payments and fail to notice or pass on EOB information about denied claims. And some groups waste money by posting all payments manually instead of using their system’s

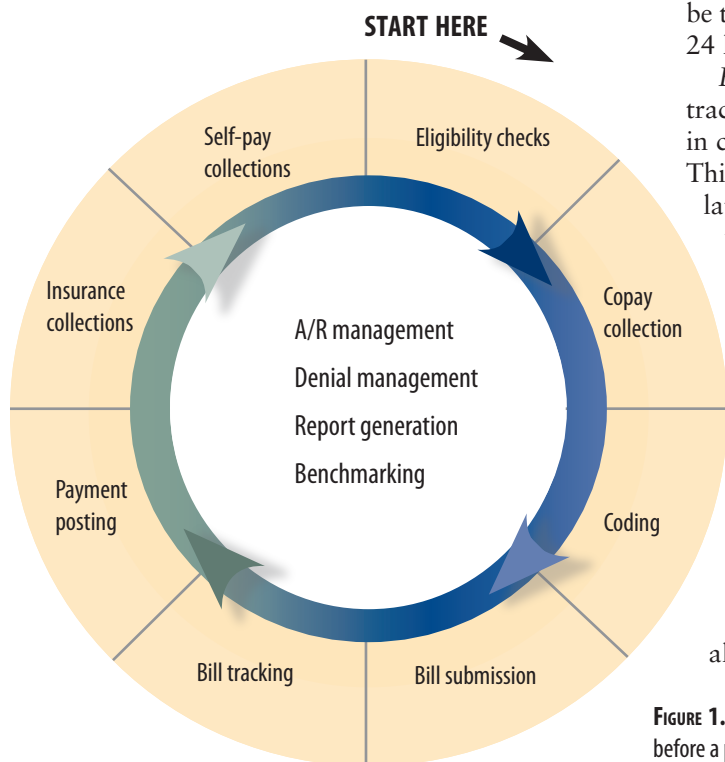


FIGURE 1. The revenue cycle management circle encompasses activities that begin before a patient’s office visit even starts. It should form a continuous feedback loop.

TABLE 1. RCM BENCHMARKS (FROM MGMA)¹

Specialty	Family Practice ²	Internal Medicine	Cardiology	Urology
Net collection	98%	99%	99%	95%
Gross collection ratio	69%	64%	44%	45%
Days in A/R	39	28	35	31
Percentage of A/R older than 90 days	8%	5%	8%	6%
Payer mix³				
Commercial	69%	⁴	40%	45%
Medicare	18%	⁴	52%	47%
Medicaid	5%	⁴	3%	4%
Self-pay	4%	⁴	3%	2%

¹ Median 2007 values.² Not employed by a hospital or integrated delivery system.³ Mean values.⁴ Insufficient sample.

ability to receive electronic remittance advice (ERA), notes Rosemarie Nelson, an MGMA consultant in Syracuse, N.Y. Medicare carriers provide ERA, as do many commercial plans.

Practices should also load their major payers' fee schedules into their software — if the program has that capability — and make sure they're being paid the proper amount by each carrier, at least for frequently provided services, observes Dunn. And don't forget to submit balances to secondary carriers. Your office may have to ferret out information about this extra coverage from patients.

A/R management. If a practice has done its job properly on the front end, the number of claims that have to be resubmitted or are left pending should be minimal. But still some payers — and patients — simply don't pay.

If your practice is big enough, Fischer suggests assigning different staff members to different insurance accounts so they get to know the people they're dealing with at each plan. Also, she says, certain types of people are better at handling patients than collecting from insurance companies.

Collections staff should perform "denial management," analyzing the reasons for claims denials so they can decide which to appeal, says Dunn. And they should keep chipping away at unpaid claims.

Regarding patient collections, Dunn notes, the more successful practices turn accounts over to collection agencies when they're 90 to 100 days overdue. Practices should have well-defined policies on self-pay collection and educate employees on them. "You can't have one person say they'll take 50 percent and another say they'll take 70 percent when a patient with a balance checks

in," she notes. Make sure you communicate your policy to patients, both in the office and on your Web site, adds Dunn.

Reporting and benchmarking. Practice administrators and physician owners should look regularly at financial reports, whether they're doing RCM internally or billing through an outside firm. Most PM systems can generate reports on such key metrics as gross and net collections ratios, days in A/R, and percentage of accounts over 90 days old.

How do you know when you're in trouble? "When a practice has a collection problem, you usually find that 40 percent of their A/R is older than 90 days," says Matthews. "Of that 40 percent, 80 percent is self-pay or patient copays. Identify the components of your old A/R, and look at your collection rate."

Aside from analyzing your own data trends over time, external benchmarks to which you can compare your numbers are available. The best known are the figures in MGMA's annual cost survey (www.mgma.com), although that report doesn't include every specialty. For a somewhat more comprehensive survey, Matthews suggests consulting the figures issued by the National Society of Certified Healthcare Business Consultants (www.smdmc.org). If you use the MGMA data, note how the average payer mix for your specialty compares with your own data. (For key benchmarks in several specialties, see Table 1.)

OUTSOURCING

Why should a practice outsource RCM functions? One reason would be a lack of experience in that area, Nel-

son says. “If you don’t have the expertise in-house, just like you’d refer a patient to a specialist, you refer your most important asset to a specialist.”

Among the factors that may account for this often-seen lack of expertise are an insufficient number of staff, high staff turnover, and an inability to attract the right people. Perhaps you’re located in an area — such as a rural town or the inner city — where too few people have the proper training. “A lot of places don’t have a labor pool that’s capable of being proficient,” notes Matthews.

Practices might also need a new PM system but be reluctant to make the investment. Perhaps a retirement or merger with another group is planned. Or the physician just feels that she can’t afford the cost of a sophisticated PM system. Although Web-based versions of some programs are available for a monthly fee, practices might end up paying more for these application service provider (ASP)-model PM systems in the long run. Plus, they don’t come with the billing and collections assistance that a billing service, RCM firm, or MSO would provide.

Bob Bohlmann, an MGMA consultant in Arlington, Texas, says that small practices often can’t afford the infrastructure to perform RCM well themselves. He draws the line at six or seven doctors for a primary-care practice, and five or six for a surgical group. On the other hand, David Scroggins, a Cincinnati-based consultant, says that even solo practices can handle RCM well, especially with recent improvements in PM software.

Others might simply be tired of the headaches of running the financial side of the practice. But don’t be fooled: Even if you outsource RCM to an outside firm, you still have to supervise their efforts on your behalf, and keep a close eye on the reports they send you.

“Every billing service has an endpoint, which is predicated to a great extent on their price. And the more they follow through, the higher the price is going to be.”

— DAVID SCROGGINS, CONSULTANT

Billing services, RCM companies, and MSOs offer overlapping services along a continuum that ranges from simple bill submission to complete management of your practice. (See Figure 2.) Although some RCM firms are glorified billing services, and some billing services go far beyond their usual job description, these types of organizations have inherent differences. Many billing services now provide Web-based access to their PM software, just like RCM firms, but only the latter typically offer choices of software.

RCM companies are also more likely than billing ser-

vices to help practices straighten out their internal processes. “An RCM company works with you as a partner, and requires you to pay more attention to the many facets of the revenue cycle, starting from the time a patient makes an appointment until their care is complete,” says Dunn. “It can help you identify the holes in your practice.”

When making a decision about outsourcing RCM, keep the following factors in mind.

Billing Services

Many billing services do little more than send out bills. “Often, physicians have abdicated the whole RCM function to a billing company, and all the company does is take the bills and submit the claims, and whatever comes in, it deposits,” says Matthews.

The services of billing firms are related to their fees. “If a primary-care practice is paying 4 or 5 percent, the services are just getting the claims out,” Matthews notes. Six percent to 8 percent is more typical of a good service, which should do collections and help practices improve their front-end work.

In exceptional cases, a billing service might charge much more, depending on how much data entry and consulting it’s doing. For example, a five-doctor primary-care group in Steamboat Springs, Colo., pays a local service 11 percent to perform all of its RCM tasks, including data entry from paper superbills it sends by courier each day. Family physician David Williams says the service is doing a much better job of billing and collections than he used to do himself, or than his former hospital employer did. The group’s year-to-date net collection ratio is 95 percent; its days in A/R range from 21 to 29 in any given month; and its percentage of A/R older than 90 days ranges from 16 percent to 23 percent.

If you contract with a billing service, Scroggins advises, make sure the service’s responsibilities are spelled out. “The agreement might just say they’ll submit your claims and bill three times thereafter, and then it will go into collection, or they’ll give you a list of accounts to send to a collection agency. Another service might promise to follow through further. But every billing service has an endpoint,

which is predicated to a great extent on their price. And the more they follow through, the higher the price is going to be.”

Scroggins warns against surrendering all billing and collection-related tasks to a service. To begin with, he says, physicians are better protected against financial losses and audits if they perform their own coding. Also, he notes, “Your in-office billing skills get lost. I’ve seen cases where the billing services perform their contractual duties, and they send you a letter saying, ‘Here are the patients who are coming off [the list of accounts] this

week.’ They’ve washed their hands of those accounts, and nobody in the office does anything to collect them.”

Make sure that the billing service agrees to supply reports at least monthly. And if the service provides your office with billing software, insist that the practice owners and managers have direct access to all the reports they’ll need to see. As with the other types of outsourcers examined in this report, be sure your contract spells out conditions of termination and guarantees that you can get your financial data back.

One other tip: Many billing services handle only one medical or surgical specialty, because of the myriad specific rules and nuances involved in billing for physicians in that specialty — find out which local services know your field.

RCM Companies

RCM firms contend that they do a better job than billing services, partly because they work with practices to maximize collections. (For a list of RCM companies, see Table 2.) But billing services also take a percentage of collections, so they have just as strong an incentive to collect as much as possible. The difference is that billing

services are more likely to compete on their fees, so they can’t provide the same services as RCM firms and others that may charge more.

Good RCM firms will assess your practice and recommend process changes before they install their software. They will also offer specific feedback about errors in claims preparation, as well as reports on a wide range of financial parameters. Some run previsit eligibility checks, too, although practices must still gather information from patients upfront.

Some RCM companies provide top-of-the-line PM software that most smaller practices couldn’t afford on their own. Although fees can run several thousand dollars per doctor for training and implementation, that’s much lower than the cost of purchasing the software on your own.

Some RCM firms have proprietary claims scrubbers that, they maintain, do a better job of detecting problems in claims than either commercial PM software or clearinghouses. Many larger firms say they have a first-pass claims acceptance rate of 90 percent to 95 percent.

When practices come to Med3000, notes Richard Schickler, the firm’s executive vice president, their claims denial rates are typically above 10 percent. Med3000

TABLE 2. RCM COMPANIES

Company Name	Product Type(s)	Company Name	Product Type(s)
Accuro Healthcare Solutions	Software, service	Med3000	Software, service, other
AdvancedMD Software	Software	MedAptus	Software
Advantage Healthcare Solutions	Software, service, other	MedAvant Healthcare Solutions	Software
athenahealth	Service	Medical Business Bureau	Service
Availity, LLC	Other	Medical Present Value, Inc. (MPV)	Software, service
Avisena, Inc.	Software, service	MedSynergies, Inc.	Software, service, other
Cairn Software	Software	Navicare, Inc.	Software, service, other
ClaimLogic	Software, service	Payerpath, A Misys Company	Software, service, other
Craneware, Inc.	Software, service	PPM: Connect	Software, service
dashboardMD	Software	Practice Insight	Software, service
Eclaims, Inc.	Service	PSC Info Group	Service
eLifeCare Solutions	Service	Purkinje	Software, service
Emdeon Business Services	Software, service	Sage Software	Software, service
Gateway EDI	Software, service	Sinaiko Healthcare Consulting, Inc.	Software, service, other
Global Healthcare Alliance	Software, service	SNB Digital Lockbox Services	Service
HealthPort	Software	SSIMED, LLC	Software, service
INCISIVE	Software, service	Transworld Systems, Inc.	Service
iSALUS healthcare	Software, service, other	ZirMed, Inc.	Software, service
McKesson	Software, service	Zotec Partners	Software, service

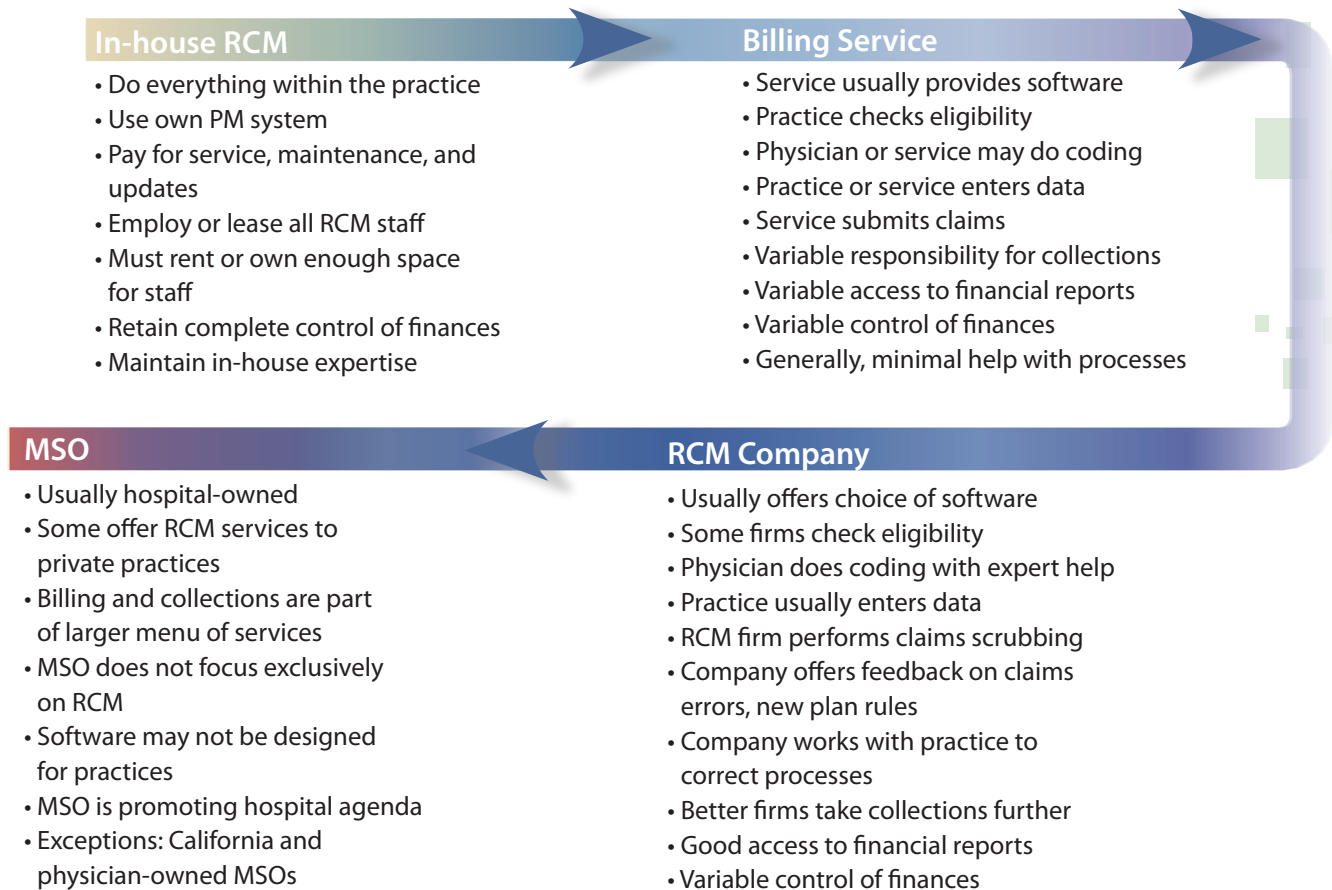


FIGURE 2. The continuum of services from in-house RCM to the MSO. Regardless of the solution chosen, tasks and responsibilities must be clearly delineated.

works hard to lower that rate below 5 percent, “because that’s our margin. If we can’t get these claims going clean, it’s never going to work for us. And the client will also be unhappy, because we have to keep calling their office to fix the claims. So both sides are incentivized to get those denials down.”

Some observers are skeptical about the ability of RCM companies to scrub claims and keep up with changing plan rules better than a good practice biller could. Matthews notes that the rules are different for every specialty, so an RCM firm’s feedback may help, say, a pediatric practice but not a hospitalist group. And Kathy Collins, who manages the Seattle emergency-medicine group, says, “Any group administrator should know insurance companies.” As for specific coding rules, she says, “That’s nothing more than understanding the RBRVS, and every year CMS puts out their publication in November.”

But some consultants believe that RCM companies can do more for your practice than the average billing service. “RCM firms are billing companies, and they throw some other things in the pot to try to differentiate themselves,” says Dunn. One company she knows of “takes the knowledge that they gain from EOBs and why things were denied by payers, and they share that with you and try to catch things before they go out.” By doing this, she notes, they “automate” the knowledge of

skilled billing people.

RCM firms, which may require practices to perform data entry, charge from 2 percent to 10 percent of collections, depending on the specialty, charge volume, and division of responsibilities with the practice. Because primary-care practices have more bills, they generally pay a higher fee. Dunn thinks a good RCM firm is worth the extra money: “From an educational standpoint, it’s often worth it, because the RCM companies will work with physicians on certain types of coding rules.”

Dermatologist Kenneth Reed, of Quincy, Mass., is very pleased with the RCM company his practice uses, saying they’ve done a much better job than his former billing service. Although one of his clerks has had to add data entry to her duties, the staff had more work before, because the billing service was always asking for chart information. The RCM firm has increased his collections, and he says he’s bringing home “substantially” more than he used to.

MSOs

MSOs, most of which are run by hospitals, manage employed physicians and may also offer private practices a smorgasbord of services, including RCM. Although all MSOs are not created equal, many are really append-

ages of a hospital billing office and may not be attuned to the needs of physician practices. These organizations also have plenty of other things to worry about and may not be as effective in RCM as a good billing service or specialized RCM firm, Dunn points out.

If you practice in California, bear in mind that most MSOs in that state focus on contracting with HMOs, often on behalf of IPAs or groups of practices, and so might not handle RCM as well as you'd like. On the other hand, some physician-owned MSOs offer RCM on an a la carte basis. Because they don't do HMO contracting and derive their income from maximizing practice income, they're likely to be more effective at billing and collections.

Good RCM firms will assess your practice and recommend process changes before they install their software. They will also offer specific feedback about errors in claims preparation, as well as reports on a wide range of financial parameters.

In general, MSO fees for primary-care offices range from 8 percent to 12 percent of collections. If they're not handling staff payroll, benefits, hiring, accounting, marketing, and purchasing, their charges fall on the lower end of that range, making their prices competitive with RCM firms.

One way to tell whether an MSO knows what it's doing with physician practices, says Matthews, is to look at its choice of PM system. If that's an extension of the hospital information system, the MSO isn't likely to be attuned to the needs of an individual private practice. It's also important to find out who the MSO's executives are — if they haven't had at least 10 years of PM experience, you're probably barking up the wrong tree.

DOING THE MATH

On average, RCM costs a primary-care practice about 8 percent of revenue. If an outsourcer would charge you about the same, you might not save cash by going this route. In fact, you may end up spending more because you'll have to retain staff to check eligibility, collect copays, follow up on accounts that the outsourcer has stopped working, and, in some cases, enter charge data or post payments.

"The opportunities from outsourcing are on the revenue improvement end," says consultant Bohlmann. "It's difficult to justify a transition to outsourcing based on cost savings." In other words, to realize a net financial

gain from outsourcing RCM, you have to add more to your bottom line from increased collections than you subtract by having somewhat higher costs.

Some practice administrators who have run the numbers doubt that they're coming out ahead financially by outsourcing. For example, Collins says her group could do better if they brought their RCM operation in-house, even after factoring in the cost of a new PM system and extra staff. Cost isn't the only consideration, though, and in this case the timing is wrong for the practice because of changes going on at the group's main hospital. The billing service that the group uses is doing a superb job, she adds: Days in A/R are 40 to 45, and the net collection ratio is 90 days, great for an emergency-medicine practice. In the long run, the ER physicians would rather do RCM themselves to maintain what they feel is better control of their finances.

Similarly, Johanna Jones, administrator of a 13-doctor ophthalmology group in Forth Worth, Texas, did a "pro forma" calculation to see what the numbers would be if the practice brought its RCM back in-house, "and it was a wash. We would have achieved about half a percent lower cost by doing that." That half a percentage point would entail considerable risk because of the complexity of the endeavor, she says.

In addition, the group's RCM process would depend entirely on her, whereas with an RCM company part of the onus is on that firm.

In the end, there's no "right" answer. Each physician and each practice has to consider its own financial situation, strategic goals, and appetite for risk. Many practices that outsource to RCM companies are "train wrecks," says Med3000's Schickler. For those practices — especially small ones that can't afford to hire a consultant — outsourcers may look like saviors. On the other hand, Nelson cites an Indiana physician who says he could outsource his billing for 8 percent of collections. "He looks at his existing costs, and they're about the same. Yet he keeps it in-house because of the extra factor of the 'devil I know.'" This physician feels he can control his destiny a little more easily without "keeping an eye on the outsourcing firm."

So whether or not to outsource is a very personal decision. Only you know what kind of financial challenges you face, what kind of in-house staff you have available, and how much control you're willing to give up. But whatever your decision, remember that the management of your revenue cycle continuum is one of the most consequential choices you will make in your professional life. ■

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