7 Ways to Immediately

IMPROVE YOUR REVENUE COLLECTION RATES

Revenue collection is a necessary part of your clinic operations, but it's also one of the most difficult. From large multi-specialty, multi-provider, multi-location to small independent physician clinics with a single provider, revenue collection remains one of the most frustrating parts of private practice.

The financial pressures of running a clinic are one of the biggest concerns for small and independent practices as well as small or medium-size group practices. Recent events have only exacerbated what was already a difficult financial maze of claims, reimbursements, patient responsibility, and bad-debt write-offs.

While patient care is and should always remain the primary focus of your clinic, your practice leadership must focus on revenue cycle management with the goal of continually optimizing collection rates. Fortunately, there are things you can do right now to collect more of the money you bill for services.

RUN REGULAR REVENUE CYCLE REPORTS

(& ACTUALLY REVIEW THEM).

An oft-repeated phrase in business is that you can't manage what you don't measure. Data is critical in revenue cycle management. The first step toward improving your revenue collections is understanding what the process looks like and knowing where you stand.

Some key performance indicators (KPIs) you should be intimately familiar with in your clinic's revenue cycle include:

DAYS IN ACCOUNTS RECEIVABLE (DAR)
This will help you determine the efficiency of your revenue cycle. The longer it takes to get paid, the less likely you will be able to collect the full amount that you are billing. The American Academy of Family Physicians (AAFP) recommends that you keep days in A/R below 50, but getting it between 30 and 40 days is preferable. It's helpful if your reports can break this down further by insurance payor, and by patient responsibility so you can understand if there are specific payors that consistently delay payments, or if your patient collection efforts need to improve. Segment your outstanding payments into buckets based on how long it's been outstanding (0-30, 31-60, 61-90, 91-120, and over 120 days).

KPIs to measure
Less than 25% of A/R should be over 120 days

Average days in A/R should be between 30-35, and not over 40 (you can also benchmark by your specialty)

CASH AS A PERCENT OF NET PATIENT SERVICES (NET COLLECTION RATE)
Your net collection rate identifies how much revenue you collect based on net patient service charges (the allowable charge). Measuring this specific metric helps you understand how well you are transferring billable services into collections while accounting for the portion you would never collect because it's outside the allowable range. To calculate it, take total billed charges and subtract contractual write-offs to get the allowable charge. Divide the amount you collect by the allowed amount to get your net collection rate.

KPI to measure
Net collection rates should be above 95%

CLAIM DENIAL RATES
What percent of claims submitted come back from payors either denied or rejected? Calculate this by dividing total number of claims denied by aggregate claims remitted.

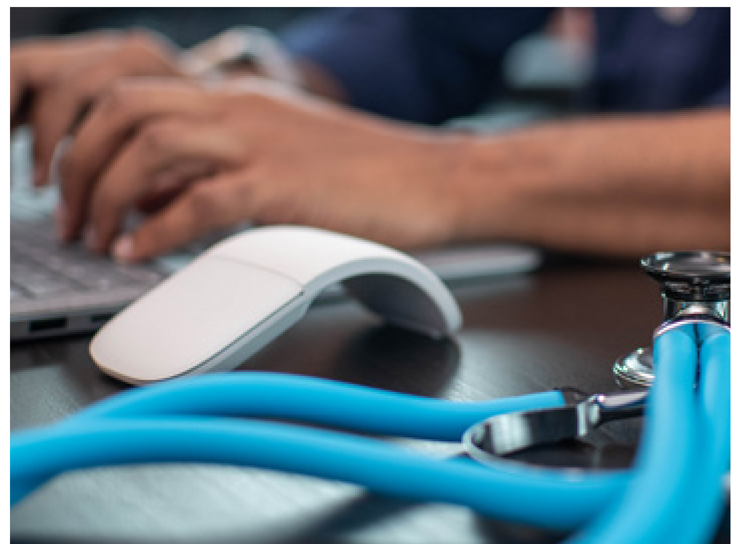
KPI to measure
Total denied claims should be below 5%

CLAIM DENIAL REASONS
Segregate your denied claims by the reason for denials to give you a roadmap of what steps you can take to improve. It's very difficult to reduce your denied claims rate if you don't understand where in your revenue cycle process the errors are occurring. We'll talk more about this is the next section.

KPI to measure
First-pass resolve rate on claims should be above 96%

COST TO COLLECT PATIENT REVENUE
How much does it cost you to collect $1 in revenue? Measure this by reviewing the total amount collected for services (on your balance sheet) and dividing it by all the costs – salaries, benefits, subscription fees, service agreements, software fees, transaction fees, and any other fixed or variable operational costs. We'll discuss why this is such an important metric in #3.

WHAT YOU CAN DO IMMEDIATELY
Set up automatic reports in your medical billing software to run at least once a week. Review reports with your office manager, revenue cycle management team, and medical coding and billing staff to identify trends (positive and negative) and create specific goals for improvement. Tackle the areas of concern one at a time to keep it manageable. Continue reporting and reviewing the data as you move on to the next issue.



FOLLOW UP ON DENIED CLAIMS & PREVENT THEM IF POSSIBLE.

For most clinics, denied or rejected claims represent a significant (and fairly simple) opportunity to immediately collect more revenue.

> The AAFP estimates the average claim denial rate for clinics at 5% to 10% of total claims (for some clinics that could even be as high as 15% to 25%)
>
> A study by The Advisory Board estimated that 90% of those denied claims are preventable
>
> As many as 65% of denied claims are never reworked because of staffing shortages, lack of time to follow up, or lack of knowledge about how to follow up

Following up on denied claims is the first step toward higher revenue collections. This will always remain a critical step, even if your denial rate is below 5%, because it represents potential revenue that you will never get if you don't follow up. However, it's also important to work on limiting denied claims as much as possible by improving workflows and processes.

THE TOP REASONS FOR DENIED CLAIMS INCLUDE:

- Missing or incorrect information (such as the patient demographic information, modifiers, or plan codes)
- Duplicate claims submissions
- Services submitted were already adjudicated with another payor
- Payor doesn't cover the services
- Missed deadline to submit a claim

Most of these errors can be easily corrected with better claims processing workflows, automated claim scrubbing, and better training for staff members who collect patient information and record data about the patient encounter before it goes to your coding and billing department.

Considering that it costs $15,000 on average for clinics to follow up on denied claims every year, significantly reducing claims denials can add money to your bottom line immediately.

WHAT YOU CAN DO IMMEDIATELY

Hire adequate staff and train them properly to follow up on claims denials. Then find at least two things you can do right away to reduce the volume of denials. If you have a significant issue with denials (above 10%), consider hiring a temporary billing service vendor to follow up on claims in the short term while you put the pieces in place to reduce denials in the future.

COLLECT MORE CASH FROM PATIENTS UP FRONT.

The burden of paying for care has shifted dramatically to your patients over the last few decades. A 2019 analysis by TransUnion Healthcare found that the average out-of-pocket expense for a healthcare visit is over $500. Even patients with private insurance still face higher out-of-pocket expenses, as many have shifted to high deductible health plans (HDHPs) as a way to keep monthly insurance premium costs lower.

In another survey 81% of respondents, especially those in smaller clinics, reported that communicating patient payment responsibility was one of the most difficult parts of collecting outstanding revenue. Patients have become accustomed to receiving services now and getting billed later. So, staff might be uncomfortable asking patients to pay up front. Remember, trying to collect after a patient leaves is always more costly and difficult.

WHAT YOU CAN DO IMMEDIATELY

Clinics can collect more revenue up front, but it requires setting expectations and following through on collections.

Draft clear financial policies that explain payment responsibility and timelines, and present that to your patients prior to arriving for an appointment, then again at the time of service.

Provide estimates of the total cost for each patient visit. When a patient knows how much it is likely to cost, they can determine whether to move forward with treatment.

Train your staff to discuss the cost and require payment (or a portion of payment) at the time of service. Staff should be able to clearly explain deductibles, out-of-pocket costs, and other insurance terminology that can be confusing for patients.

Use kiosks or an online check-in that prompts patients to pay co-pays and outstanding balances before the appointment.

Offer flexible payment plans to allow patients to pay off high balances monthly instead of requiring it all at once.

REVAMP WORKFLOWS TO SUPPORT MEDICAL CODING & BILLING EFFICIENCIES.

There is a reason that some of the top companies in the world focus on efficiency and process management. From the early days of Henry Ford's first mass production lines to the vast warehouses of Amazon Fulfillment Centers today, these companies recognize the importance of processes that can be analyzed, improved, and replicated over and over.

In 1900, cars were made entirely by hand by a single person from start to finish. The cost of a vehicle was $1,000, and while the inflation-adjusted price, which was more than double the average salary of $438 per year (if that were still the case today, an average vehicle would cost $156,849 and would remain something that only the very wealthy could afford). Henry Ford introduced the idea of assembly-line manufacturing in 1913, which significantly reduced the total cost to produce a vehicle. By 1924 the average cost of a vehicle was $265, while average income had risen to $3,481—less than 10% of average annual income. The difference? Assembly line production techniques dramatically lowered the cost to build an automobile so more people could afford them, and the profit on each one was higher.

While you might not like to think about your medical practice like a manufacturing facility, or your patient care services like an 'assembly line,' the same concepts that worked for Henry Ford hold true in medicine. That is, the more routine you can make your processes, the more efficient and cost-effective they will be for everyone.

The revenue cycle management processes in your clinic have a lot of moving parts. It begins when a patient contacts you to schedule an appointment and doesn't end until you have collected the maximum payment for services rendered. At every step along the way, there are opportunities to streamline processes that can lead to higher collections.

SCHEDULING

Staff should review every scheduled appointment at least twice prior to the visit to prevent errors with insurance or patient information (such as a misspelled name or the wrong insurance ID), which are a significant source of claim denials, and are completely preventable. Electronic eligibility verification tools are very affordable and can be set to run automatically.

PRE-VISIT VERIFICATIONS

Run a second insurance verification at least 24 hours before a patient's appointment. If the appointment was scheduled several weeks (or even months) ago, insurance information may have changed. This gives staff time to follow up if there is an issue.

PATIENT CHECK-IN

Allow patients to complete intake forms at home, electronically before they arrive at your clinic, or through kiosks or tablets when they arrive. Patients can easily verify their information—name, address, insurance coverage—and correct errors before the visit.

EHR

The right EHR can provide alerts, reminders, and notifications to capture all the relevant information during the patient visit and avoid missing information that will affect your claim submissions.

CLAIMS DENIALS

Create a workflow for staff to check for and follow up on any denied claims immediately. Leverage skills-based worklists so your collections staff is able to work with payors they are most familiar with. Most payors have time limits of when you can file, and missing a deadline means leaving money on the table.

WHAT YOU CAN DO IMMEDIATELY

Appoint someone from each functional area (or a single person if you have a very small staff) to outline every workflow, identify bottlenecks or inefficiencies, and propose at least one change that will improve revenue collection efforts.

INVOLVE YOUR ENTIRE TEAM IN REVENUE COLLECTIONS.

Physicians and care providers often hear the word 'silos' in reference to the need for specialists and primary care providers to work better together in caring for patients. But silos can also exist within a clinic, even in smaller clinics and group practices. Whether on purpose or not, staff members and care providers can become so focused on their own area that they lose sight of the big picture. This isn't good for patient care, and it can also be detrimental to your revenue cycle.

Every person in your practice has a role to play in ensuring that claims are adjudicated quickly, and each member of your team must take ownership of their role in the process. That requires properly training everyone on how their individual actions lead to improved revenue collections. Too many clinics assume that the revenue collections process is solely the job of the medical coding and medical billing staff and miss clear and obvious ways that other staff members and providers could make that job easier and more efficient.

This also requires cross-training so your staff get a more holistic view of all the things that can impact revenue collections. Someone may not be aware, for example, that something they are doing has a ripple effect. For example, a physician may be documenting something in the EHR that makes it harder for the coder to determine the right billing codes and leads to denied claims.

WHAT YOU CAN DO IMMEDIATELY

Set a goal to reduce denied claims to a specific level. High-performing clinics have first-time denial rates below 5%, but you should set a realistic goal based on where you are today. If your current denial rate is 12%, aim to get it to 10% right now, then eventually work toward 5% or below.

- Make everyone on your team aware of the goal
- Train each person on how they can help improve collections
- Provide frequent updates on your progress
- Offer a reward to the whole clinic when you achieve the goal
- Make it into a game or a friendly competition to enhance participation

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ELIMINATE ERRORS BY INTEGRATING YOUR CLINICAL SOFTWARE.

Digital tools are an incredible resource for improving the delivery of care to your patients, but these tools can also be detrimental in the revenue collection process. That is particularly true for systems that are not integrated and do not 'talk' to each other. Every manual intervention in your revenue cycle process – for example, a staff member who has to transfer information from your scheduling database to your EHR manually or download and upload patient data from the EHR into the billing system – slows your process and creates a chance for errors.

Even if you follow all the steps outlined in this eBook, disjointed systems can undo all the work. An integrated software system seamlessly shares data from the moment a patient contacts you to schedule an appointment through the billing, claims, and payment process. This removes all opportunities for data entry errors, manual process errors, or bottlenecks that slow down claims submission and payment collection.

WHAT YOU CAN DO TODAY

It's not always realistic to replace your entire software suite immediately, but you can start planning for the future right now. The easiest and most cost-effective way for small and independent clinics, and small or medium-size group practices to move toward full integration is to find a software vendor that offers a unified and modular system you can grow over time. These systems allow you to achieve full integration immediately – with the flexibility to grow and expand as you and your staff are ready.

EXPERT TIP

Many software systems will say they are 'integrated' or can integrate with other systems through what is called an API (application programming interface). However, it's important to understand that software from different vendors will not always integrate seamlessly as a native system and APIs can still have issues that require manual work by your staff. A fully unified platform from the same vendor is always preferable over disparate systems from multiple vendors because data accuracy improves, and workflow processes become much more automated.

MAXIMIZE TECHNOLOGY IN REVENUE CYCLE MANAGEMENT.

Technology has the capacity to make revenue cycle management much easier for your practice, but it requires the right tools, implemented effectively, to achieve the maximum potential.

The AdvancedMD suite of software solutions offers several opportunities to help improve your revenue collections by:

Unifying every part of your practice management software with a single database to reduce errors in data transfer, patient record reconciliation and manual data entry.

Providing tools that help patients understand their payment responsibility prior to their appointment.

Providing tools for front desk staff to automatically verify insurance and patient information.

Allowing patients to pay in convenient ways, including online before they check in for an in-person visit or attend a telemedicine visit, or through a patient portal or online billing system after receiving a bill or text/email payment reminder.

Integrating EHR, medical coding, claims management and the clearinghouse to make claims submission simple, accurate and seamless.

Simplifying the process for working and resubmitting denied claims.

Offering robust claims-scrubbing to check claims before submissions and reduce denials before they happen.

Providing automated reports to help you monitor revenue cycle KPIs.

Simple steps today, and the right technology in your practice, can immediately boost your bottom line and improve revenue collection. Talk to AdvancedMD today about how our integrated software tools will help.

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