Insider Tips for Office Managers & Administrators

GET PAID FASTER

Getting revenue cycle management right means you get **paid faster.**

The revenue cycle in healthcare[1] is a difficult thing to manage, and even practices that do it well find it confusing and frustrating at times. It's also an essential part of healthcare because you can't run your clinic without it. Getting revenue cycle management right means you get paid faster and you can collect on more of your total billed charges. We'll discuss ways to help you use technology to your advantage in the revenue cycle and avoid some of the most common mistakes that can lead to claims rejections and denials.

WHY YOU'RE NOT GETTING PAID

When it comes to the revenue cycle, a lot of things have to go right for you to capture the maximum revenue for the services rendered to your patients.

- Patient demographic information must be correctly entered
- Insurance information must be correct and up to date
- The patient's insurance must be in-network and cover the procedure
- Prior authorization must be obtained when necessary
- Documentation in the EHR must clearly show services provided and medical necessity
- CPT and ICD-10 codes must be correctly applied
- Claims must be filed within the specified timelines for each payor
- Denied claims must be reworked and resubmitted (also within specified timeframes)
- Patient balances must be billed and collected

Unfortunately a lot of office managers, administrators, and physicians think of the "revenue cycle" as the claims process. In reality it encompasses every part of the patient care process and involves everyone on your team. While the reasons for a preventable denied claim or delayed payment vary, they often boil down to inefficient or broken processes and lack of technology that can aid in getting payments faster.

COMMON MISTAKES THAT DELAY PAYMENT

The most common mistakes that can delay your payment and make it harder to collect the highest percent of allowable charges include:

Data entry errors at the time of scheduling

Errors in manual data entry when information is transferred between systems

Incomplete documentation

Inaccurate coding

Missed deadlines to submit a claim or rework and resubmit a denied claim

Not informing patients about their payment responsibility upfront

Not following up on patients' unpaid balances

HOW PRACTICE MANAGEMENT SOFTWARE CAN IMPROVE YOUR REVENUE CYCLE

One of the most important tools for a clinic is medical billing and practice management software[2]. Where many practices fall short is having separate systems that don't work together, or not using the available technology to its maximum capacity to improve your revenue cycle. Practice management software and medical billing software can dramatically improve your ability to collect revenue quickly and maximize what you are able to collect.

SOFTWARE INTEGRATION

A common buzzword in healthcare is the idea of "integration," but many clinics do not have truly integrated software. Disparate systems patched together using APIs[3] often cannot share data seamlessly, leaving information gaps or requiring manual data entry that slows down your revenue cycle.

A quick fix (i.e., an API) to connect two existing legacy systems might seem like a cost-saving measure—and probably is less expensive than a new, fully integrated practice management system in the short-term—but it will cost you a lot in the long run by creating inefficiencies and contributing to lost revenue.

Integrated software[4] allows patient data and clinical data to flow seamlessly through the entire patient journey:

Scheduling
Gather accurate patient demographics

Insurance verification
Ensure correct information to bill the right payor.

EHR
Track and manage clinical notes and documentation essential for claims.

Claims submission
Code properly based on care provided and submit information to payors based on their specific requirements and timelines.

Denial management
Follow the claim to ensure it's been paid and wasn't denied or rejected; have a process to follow up on denied claims immediately.

Patient collections
Generate a bill for any unpaid balance that was not covered by insurance and send it to the patient.

Bill pay
Collect patient payments and allocate them to unpaid balances

All of these steps require information about the patient, the payor, and the clinical care. If this information cannot be transmitted between programs quickly and accurately it leads to unnecessary errors and delays. Truly integrated cloud-based practice management software[5] shares a common database accessible by staff and physicians with a single click.

IMPROVE & AUTOMATE ELIGIBILITY VERIFICATION

Millions of claims[6] are denied every year due to insurance eligibility errors, such as:

- Services not covered by the patient's insurance
- Insurance coverage terminated prior to the patient's appointment
- Patient's maximum benefit was already met
- Your clinic is out of network
- Procedure requires prior authorization that was never obtained

These denials are frustrating to you and your physicians, but also to your patients. The worst part of a denied claim is the fact that most could be avoided with proper insurance eligibility verification. Practice management software can automatically check for issues or errors at the time a patient schedules the appointment, and again right before the appointment occurs (checking twice can help you avoid a situation where insurance has been terminated or has changed since they scheduled the appointment). Batch checks can quickly verify multiple patients without requiring any manual work by front office staff.

PROVIDE COST ESTIMATES

The way payments work in healthcare—claims submission to a third-party insurance payor after services are rendered, and collections that occur months after the patient visit—creates confusing, bureaucratic, and opaque pricing. This frustrates patients, providers, and administrators.

Four in 10 adults[7] said they would have to borrow money, sell something, or skip paying an unexpected bill of $400 or more in a 2018 Federal Reserve report. Medical bills that are several hundred or several thousand dollars—especially when the patient isn't prepared for that cost—are unlikely to be paid. Black Book's Revenue Cycle Management survey found that 83 percent of clinics[8] with five or fewer physicians struggle with delayed payments from patients with high deductible health plans (HDHPs).

As healthcare consumerism increases, patients are looking for clear information about what their costs will be for healthcare services. A TransUnion survey[9] showed that 75% of patients use provider or insurance websites to estimate costs before seeking care. Average out-of-pocket costs[10] exceeded $1,800 in 2017 and are climbing by double-digit rates year over year. Only half (51%) of patients in the TransUnion survey said they received clear information about costs before getting treatment, but 65% said they are more willing to pay when they know the costs upfront.

Provide an estimate of the total patient responsibility before the appointment, especially for people without insurance or with a high-deductible plan who will be shouldering a significant portion of that cost. Front office staff should be collecting as much as they can at the time of service.

ELIMINATE DATA ERRORS

Another common reason that payment gets delayed is simply that the information on the claim is wrong. It might be an error in the patient's social security number, a transposed or missing number in the insurance ID, or the wrong date of birth. Properly training staff to double-check work can help reduce these errors, but there are also ways your practice management software can help:

Integrated systems with a single database eliminate the need for multiple rounds of manual data entry, which is a common reason for data errors[11].

Electronic check-in processes[12] allow patients to view and double-check their own data before the appointment, and correct errors.

Clearinghouse services[13] check for errors like outdated or incorrect CPT codes.

REPORTING

Reporting is perhaps the most underappreciated way to improve the revenue cycle, get paid more, and get paid faster. Your software should generate automated reports that you and your physicians can easily analyze for key performance indicators (KPIs)[14] like:

First-pass resolution rate: the number of claims that get through without denials on the first submission (aim for a FPRR of 96% or higher) Net collection rate: the total amount you collect as a percentage of allowable charges (aim for 95% or higher)

Claims denial rate: what percent of claims are denied (aim for a denial rate of 5% or lower) Days in accounts receivable: how long it takes you to collect revenue (aim for an average of 30-35 days)

Bad debt write-offs: allowable charges that you cannot collect and write off as bad debt (aim for less than 1.75% of total charges[15])

TIPS TO SPEED UP PAYMENT IN YOUR CLINIC

Experts in revenue cycle management[16] agree that automation and technology hold the most promising keys to improving efficiency.

To sum up what we discussed above, are a few tips to get paid faster in your clinic:

Verify patient information on the first phone call
Name, birthdate, insurance ID.

Verify your provider information on all claims submissions
Address, name, contact information, NPI.

Verify insurance eligibility twice
Once at the time of scheduling, a second time the day before the appointment. Use software automation features to make this easy.

Collect upfront when possible
Provide an estimate of charges to the patient and collect as much as you can either before (at check-in) or immediately after the appointment (at checkout).

Provider documentation
Train providers and staff on proper documentation so coders and billing staff can quickly verify and complete claims.

Stay updated on changing codes
Use the most recent CPT[17] or ICD-10[18] codes, and code to the highest level of specificity to get maximum reimbursement. Or use a third-party medical billing service if your clinic is smaller and you lack the resources to do it in-house.

Use a clearinghouse
These services check every claim for errors, including insurance eligibility, coding errors, and other simple things you can fix before submitting the claim.

Create workflows for denied claims
Immediately investigate and re-work denied claims so you can submit them before the deadlines pass.

Review key revenue cycle metrics regularly
Sit down with physicians (and executives in medium-size group practices) to review metrics and identify areas of concern early. Act immediately to correct problems with actionable solutions.

Get started with better software to improve your RCM

Take the first step toward better revenue cycle management with an integrated software solution from AdvancedMD. Contact us today[19] to schedule a live demo and learn how we can help your practice.

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