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MC03
Billing and Revenue Cycle Management: Maximize Your Practice Reimbursement

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AAOE® Program of 2022

September 30 – October 3, 2022 | Chicago, IL
McCormick Place

Master Class (MCO3)

Billing and Revenue Cycle Management: Maximize Your Practice Reimbursements

Senior Instructor:
Curt Hill

Co-instructors:
Donna Connolly, MBA
Jana Holt, CPC, CPOC, CPMA

AAOE 2022 | Master Class Presenters

Curt Hill

President & CEO, Practice Management Resource Group
Senior Presenter

Curt Hill is the president and chief executive officer of the Practice Management Resource Group, Inc (PMRG), a leading provider of revenue cycle management services and financial performance consulting for ophthalmology practices. Under his leadership, PMRG has grown to provide billing services to over 65 ophthalmology practices, including all of the subspecialties and ophthalmology-specific ambulatory surgery centers.

Curt has worked in a variety of industries as diverse as education, software, hospitality services, and now healthcare. In an executive capacity, he has been successful in every venture he's taken on.

Donna Connolly

Chief Operating Officer — Practice Management Resource Group

Donna Connolly has over 30 years of experience in working with health receivables and operations management. Donna spent over 15 years with Health Receivables Management, a for-profit division of Rush Presbyterian St. Luke's Medical Center in Chicago. While there she served as a General Manager, Director of Operations and Director of Finance and Marketing. She was also the Executive Director of the Lincoln Foundation for Performance Excellence, Illinois Baldridge based quality award program, which gave her additional insight into operational auditing and quality management. Donna is a co-founder of the PMRG and is responsible for managing the operation center in Tinley Park, Illinois. Donna holds a Master of Business Administration in Finance from DePaul University and a Bachelor of Science in Marketing from the University of Illinois.

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Jana Holt, CPC, CPOC, CPMA

Consultant — Practice Management Resource Group

Jana Holt is a senior consultant and project manager at the Practice Management Resource Group. Jana has been in healthcare for 27 years, 21 of which were as a practice administrator. She has a depth of experience in general ophthalmology and retina. She is a Certified Professional Coder (CPC), a Certified Professional Ophthalmic Coder (CPOC), and a Certified Professional Medical Auditor (CPMA). Her expertise consists of evaluation of practices for efficient billing practices, medical code auditing and education for physicians and their staff, medical practice operations and finance, healthcare compliance, government healthcare regulations, and human resources and staff education.

Billing and Revenue Cycle Management: Maximize Your Practice Reimbursement

AAO 2022

Practice Management Resource Group
www.medicalpmrg.com

- Curt Hill, CEO
- Donna Connolly, COO, MBA
- Jana Holt, Director of Consulting Service, CPC, CPOC, CPMA.

Financial Disclosures

- Donna Connolly
- Curt Hill
- Jana Holt

The presenters have financial interests in providing outsourced billing services to ophthalmology practices, relative to this topic.

Introduction

- What are the secrets to having every claim get paid as it should and in a timely manner? At the heart of it, that's what this course is designed to address.

- Each and every component in the process is important, and a deficit or shortcoming in any one of the components will degrade collections.

- That said and acknowledged, there are key components. Aggressively and thoroughly managing those is the "secret!"

Introduction

The key components that we'll cover in the course:

- The building blocks of the entire revenue cycle
- Essentials for setting up the staff to be effective
- Monitoring performance by generating meaningful reports
- And a few other things relevant to effective revenue cycle management…

Introduction

- This workshop is designed to provide the tools for a physician and/or practice administrator to manage the entire billing and collections process.

- It is not intended to provide the detailed knowledge to carry out every aspect of billing (e.g., we will not show you what goes into each and every box of the CMS 1500 claim form).

Introduction

- Everything that happens in the practice, every result produced, is a function of actions taken or not taken.
- The effectiveness of the actions taken (or not taken) can be measured and indicated by the various metrics - much like a physician might assess a patient by measuring things like intra-ocular pressure.

Introduction

When the results are not being produced to the satisfaction of the owners/managers of the practice (the revenue cycle is less than optimal), you have one of two places to look to bring effective management:

- The people working in the revenue cycle process are not doing the right work or are not doing it sufficiently or completely.
- Something in the revenue cycle process is not well designed, is not working as its designed or it is broken.

Introduction

- Ultimately, what you as the manager of revenue cycle have access to are the actions people are taking and the process in which the actions are being taken. A common misconception is that you manage the numbers. Numbers cannot be managed – only the actions and processes that produce those numbers are manageable.
- What you as a manager want is to have designed a solid process and have the data to know and understand what is happening by the people taking action in the process for collecting practice revenue.

Management

- Effective management is not necessarily having all of the answers. More often than not, it is a function of formulating and asking the right questions!
- What questions are you asking, and are you getting the information you need to answer those questions?

Management

- What there is to manage is predicated on what the management and owners are out to accomplish. In this course, we'll be looking at managing the revenue cycle.
- Generally, it is:
  - To be paid for the clinical services provided
  - To provide management data that displays the financial health

Revenue Cycle Management

The Revenue Cycle

- This is the cycle of turning clinical services provided by the physicians in the practice into money collected from the various payers the practice is contracted with as well as the patients and includes all the steps required to have that happen.
- There are discrete and a finite number of steps in the cycle, and when these steps are well-designed and managed effectively, the money comes in from the services provided as expected and in a timely manner.
- That is the game!

Revenue Cycle Management

The Building Blocks

- The Front End
- Medical Record Documentation
- Charge Capture
- Correct Coding
- Charge Entry
- Claim Transmission
- Payment Posting
- Denial Management
- Accounts Receivable Management

Revenue Cycle Management

The “Other” Stuff

- Reporting
- Contracting
- Credentialing
- System Selection and Set up
- Outsourcing
- Staffing
- Benchmarking

Revenue Cycle – The Front End

Where It All Starts

- In many practices, not much thought is given to the front-desk process as part of your revenue cycle. The front desk is just where appointments are made, and the phone is answered.
- But the front desk is where an effective revenue cycle management process starts.
- We will cover the importance the following items play in your revenue cycle:
  - Making a patient appointment
  - Verifying insurance information and patient eligibility
  - Appointment Check-in

Revenue Cycle – The Front End

Making Patient Appointments

- The revenue cycle starts when a patient appointment is scheduled.
  - New Patient appointments
  - Established patient appointments

Revenue Cycle – The Front End

New Patient Appointments

- If your practice relies on referrals from other physicians or practices, consider having a standardized referral form or check-list that will enable you to collect the vital patient information.
- The referring physician or practice can complete the referral form or check-list and send it to your practice via fax or secure email
- If the referring physician or practice calls your office to make the appointment, be sure the receptionist or scheduling coordinator has the standard form to complete all necessary and vital patient information
- For a new patient that calls your office directly to schedule an appointment, collect the necessary information directly from the patient using a check-list.

Revenue Cycle – The Front End

New Patient Appointments

The referral form and/or check-list should include the minimum following information:

- Patient Full Name
- Patient DOB
- Patient phone number/contact information
- Patient Insurance Company Name
- Patient Insurance ID# and Group#
- Insured party name and DOB (if different from the patient)
- Request a copy of the patient's insurance card if possible

Additional Information that you might consider on your referral form and/or check-list

- Patient Address
- Reason for the appointment
- Referring Physician name/practice
- Fax number to communicate appointment date and time back to the referring physician/practice

Revenue Cycle – The Front End

Established Patient Appointments

- Verifying the patient information contained in your Practice Management system is key when scheduling established patient appointments.
- It can feel redundant for your staff, but it is so important to ensure the information you have on file for the patient is accurate and correct even if you saw the patient last week or last month.
- Patient demographic information, such as address and phone number, or patient insurance information can change at any time and patients don't always think about updating this information with their doctors.
- Your staff should always verify the following information when scheduling an established patient appointment:
    - Is your address still _____?
    - Is your phone number still _____?
    - Do you still have _____ insurance?
- If there have been any changes, be sure your staff updates the information in your practice management system to reflect the correct information. Have your staff make a note in the account as well indicating the demographic and insurance information was verified/updated with the date.

Revenue Cycle – The Front End

All Appointments

- After verifying all the demographic and insurance information is correct, it is also important to communicate financial expectations with the patient regardless if the patient is new or established.
- Patients like to know what the financial obligation is prior to arriving for the appointment. It will cut down on patient frustration and possible front desk confrontations if patients understand their financial responsibilities.
- Just making sure a patient understands that they will be required to pay all co-pays and estimated deductibles and co-insurance at check-in or check-out, even if you do not have an exact amount at the time the appointment is scheduled, can ensure the patient understands there will be a financial obligation at the time of the appointment.

Revenue Cycle – The Front End

Insurance Verification and Patient Eligibility

- Most practice management systems or claims clearinghouses have a method to verify the eligibility of a patient's insurance information. If you do not have this ability through your PM system or clearinghouse, you can usually check insurance eligibility through a specific payer provider portal or website.

Revenue Cycle – The Front End

Insurance Verification and Patient Eligibility

- Your staff needs to verify the following information:
- The patient is currently eligible for benefits
- The financial details of the policy
    - Co-pay information
    - Deductible information
    - Co-insurance information
- Plan Benefits (what is covered)
- Verifying patient insurance eligibility and benefits should be done prior to the appointment for all patients, new and established. Any patient that insurance cannot be verified should be flagged for the front-end staff to gather the correct insurance information at check-in.

Revenue Cycle – The Front End

Insurance Verification and Patient Eligibility

Verifying benefits prior to a patient's appointment can also ensure the accurate collection of co-pays, deductibles and co-insurance amounts at the time of service.

Your practice should have an employee dedicated to running benefits and eligibility for all new and established patients to:

- Contact a patient for the correct insurance information if the insurance information on file comes back as ineligible/can not identify.
- Contact the patient prior to the appointment to let them know what the estimated amount due at the time of service. This can be especially important during "deductible season" (January to April) when most services are being applied to patient deductibles.
- Note the patient's account or communicate in some way with the reception and/or cashier any co-pay, deductible or co-insurance that will be due at the appointment ensuring accurate collection of the patient's responsibility for the service.
- Verify if a prior-authorization is required for a procedure or service that needs to be performed during a visit.

Revenue Cycle – The Front End

Appointment Check In

- Registering a new patient, or updating the registration information for an established patient, in your Practice Management system is one of the most important steps in your revenue cycle.
- New patients
  - Complete registration paperwork
  - Copy or scan current insurance card
  - Copy or scan photo ID to verify valid insurance information (does the insurance information and the patient ID match)
  - Take a photo of the patient for the chart or practice management software
- Established patients
  - Update registration paperwork annually
  - If established patient seen more often then annually, ask the patient to verbally verify demographic and insurance information at each visit

Revenue Cycle – The Front End

Appointment Check In

- If your front-end staff does not enter all the patient demographic and insurance information correctly, it can cause claim rejections and delays as well as wasted time following up and making corrections.
- It is important to make sure your front-end staff receives the proper training AND FEEDBACK for these timely and costly mistakes to ensure accurate data entry from the start.
- Keep a scorecard of claims going out with complete and accurate demographic and insurance information and feed that information back to the front-end staff.

Revenue Cycle – Patient Encounter

Medical Record Documentation

- Whether using an EMR or handwriting an exam note, it is important that the documentation tell the “story” of the visit. That story begins in the work-up with a strong chief complaint. The chief complaint is the first “chapter” in your story and will set the “plot” for the rest of the visit.
- The examination by the provider and the findings of that examination are just as, if not more important, as the chief complaint.
- Key words in your documentation can make the difference between the note supporting your exam code choice or falling short. Try to include these phrases when possible:
    - Worsening
    - Slightly worse
    - No improvement
    - Slightly improved
    - Unchanged
- Avoid words like:
    - Stable

Revenue Cycle – Patient Encounter

Medical Record Documentation

- Documenting the examination is key to ensure proper payment for the work you or your physician does! The insurance companies will look for any reason to avoid or delay paying. Do not give them one!
- Document everything you do in your exam and every change in the patient's condition.
- Document every diagnosis code in your impression and plan. If it is a new diagnosis or condition, be sure to note that it is NEW on your impression/plan.
- If you are starting or continuing a prescription medication, be sure to note it is a prescription medication that you are prescribing or continuing the patient on (vs OTC).
- Be sure to note when you provide patient education whether it be verbal or written education, be sure and note it in the impression/plan.
- Including key words and the above documentation can support your medical decision making.

Revenue Cycle – Patient Encounter

Medical Record Documentation

- Include in your compliance plan or your practice policy and procedure manual a written policy that addresses key medical record issues such as:
- Timeliness for completion of the record.
    - The record should be signed within 48 hours of the patient's visit.
    - If a change needs to be made to the record after the note is signed, the change needs to be made via addendum. Do not "un-sign" the chart, correct it, and then re-sign it.
- Verifying patient identity by two identifiers such as the patient's full name and DOB. Do not ask the patient to verify what you have on file, ask the patient to state their full name and DOB.
- Signing and dating informed consent for procedures
- Address what the clinical staff is responsible for documenting (work up technicians, scribes, etc.)
- General guidelines on what an examination note and procedure note/operative report should include.

Revenue Cycle – Patient Encounter

Charge Capture

- Charge capture is ensuring all the services and procedures provided to the patient are captured for billing purposes.
- Accurately and completely capturing all charges at the time of service is essential for ensuring that the services the physician is providing are paid fully and in a timely manner.
- This is a critical piece of the revenue cycle puzzle.

Revenue Cycle – Patient Encounter

Charge Capture

- There are many ways to achieve accurate charge capture.
  - Using a “charge ticket” or “encounter form” to manually note on a form what exam, services, testing, and/or procedures were performed for the patient. Most charge tickets or encounter forms also include the ICD-10 code(s) that support the service(s) furnished to the patient. Many practice management systems offer custom, pre-filled encounter forms that can be printed.
  - Some EMR systems and Practice Management systems offer seamless communication that can eliminate the need to use paper encounter forms or charge tickets. Check with your EMR and PM systems to see if this is possible for your practice.
  - If your EMR system and Practice Management system can not interface or communicate charges, there are third party charge capture software packages available for medical professionals that can interface with your EMR and/or PM system.

Revenue Cycle – Patient Encounter

Charge Capture

- Whether using a hand-written encounter form or “electronic” encounter form, the following guidelines should be followed:
    - The practice should have a written policy in place that identifies who on your staff is responsible for marking the services and procedures on the form.
    - The encounter form should be updated often to reflect correct and current CPT codes, diagnosis codes, and services.
    - The diagnosis, service(s) provided, procedures performed, etc. that are marked on the encounter form should be supported by the documentation in the note.
        - A random internal audit, five to ten records per provider per month, should be performed to ensure the documentation supports the charges captured on the charge ticket or encounter form.
    - For non-office encounters (inpatient and/or outpatient encounters) your practice should establish a process to ensure proper capture of these charges. Providers and staff should work closely to establish and determine the best process for capturing all non-office related charges.

Revenue Cycle – Back End

Correct Coding

- The person in the practice responsible for choosing or verifying the correct code is chosen vary widely. The person or persons responsible for choosing the correct code(s) for diagnosis, services, testing, procedures, etc. must receive ongoing education to stay up-to-date on the ever-changing coding guidelines and have access to various coding resources.
- The person in the practice responsible for selecting the correct code for an encounter can include:
    - Physician
    - NPP
    - Clinical staff such as a nurse, COMT, COA, COT, Scribe, etc.
    - Billing staff member/Charge entry employee
    - Certified Coder (CPC) or Certified Specialty Coder (i.e. OCS, OCSR)

Revenue Cycle – Back End

Correct Coding

- Some Practice Management systems frequently have an integrated charge capture and “scrubbing” system in place that can assist your staff at choosing a CPT code that is supported by the documentation in the note; however, these systems do not typically ensure capture of all services furnished nor correct choice of ICD-10 code.

Revenue Cycle – Back End

Correct Coding

- Although having a certified coder on staff is not a requirement of CMS or many insurance payers, it is highly recommended.
- A certified coder has received specialized education and passed a competency examination ensuring they have the knowledge necessary to ensure correct coding for your practice. Additionally, they are required to participate in continuing education to maintain their certification.
- If your practice chooses not to employ a certified coder and instead chooses another staff member to be responsible for ensuring the correct code for an encounter has been selected, please ensure that staff member or members receive coding education on a regular basis, at least annually.

Revenue Cycle – Back End

Correct Coding

- Get help choosing the correct code:
  - Network with similar practices. Reach out when dealing with a difficult procedure or diagnosis.
  - Know payer-specific coding guidelines especially when they differ from standard coding guidelines
  - Subscribe to an online coding resource (AAPC, OPTUM, etc.)
  - Specialty societies can offer assistance for coding questions

Revenue Cycle – Back End

Charge Entry Review

- Even though your practice may have coded thoroughly and correctly, if the charge entry process is not completed accurately and in a timely manner, your reimbursement can be impacted.
- Whether manually entering a charge into your practice management system or verifying the codes on a claim sent from your EMR to the PM system through an interface, the information on the claim must be verified to ensure claim accuracy and proper transmission through the clearinghouse to the payer.
- Check to see if there are specific payer guidelines in place and modify the charge accordingly.

Revenue Cycle – Back End

Charge Entry Review

- Verify accurate patient demographic and insurance information. These item are key!
- Pay attention to:
    - DOS
    - POS
    - Provider Name
    - Modifiers
    - Referring physician information
    - Units
    - NDC for J-Codes
    - Prior authorization number (if applicable)

Revenue Cycle – Back End

Claims Transmission – Electronic Claims

- Typically, clearinghouses are used to electronically transmit claims to third-party payers. Claims are uploaded to the clearinghouse from your Practice Management software.
- Reports are generated by your clearinghouse that will show the number of claims that were transmitted, if the claims were transmitted successfully, or if a file was not transmitted and why.
- Your clearinghouse should also provide a report for any claims that were rejected by either the clearinghouse or the payers.
- Any rejections should be worked immediately.

Revenue Cycle – Back End

Claim Rejections

- A claim is rejected when an error is identified preventing the claim from being processed. A claim rejection can be generated by your practice management software, your claims clearinghouse or the insurance payer.
- Monitoring claim rejections can help you manage and educate your front-line employees when keying errors create claim filing issues.
- Claim rejections also offer you important insight into payer specific guidelines and claim submission rules.

Revenue Cycle – Back End

Claim Rejections – Practice Management Software

- Your practice management software should be your first line of claim rejections. Most practice management software can be customized with edits that will help identify claim errors before the claim is sent to the clearinghouse. Check with your practice management software vendor to see what edits can be implemented in your software. Some examples include:
    - Missing demographic information such as missing SSN or DOB, Ins ID#, Patient/Insured Name mismatch, etc.
    - Missing or invalid ICD-10 codes
    - Billing an exam or procedure (or other service) in the post-op period of another procedure

Revenue Cycle – Back End

Claim Rejections – The Clearinghouse

- The next level of claim rejections will be accessible through your clearinghouse. These are usually in a report format and updated daily. These rejections may either be from the clearinghouse or a payer (insurance company) rejection.
- Some examples of clearinghouse and/or payer claim rejections are:
  - Invalid Subscriber ID / Patient can not be identified / Member not on file
  - Invalid/Incorrect ICD-10 code
  - Inappropriate Modifier
  - Missing claim information

Revenue Cycle – Back End

Claim Rejections – Insurance Payers

- The last level of claim rejections will come to you directly from your insurance payers either through your clearinghouse or through provider web portal.
- Rejections sent by the insurance payer will be specific to that payer's edits set up in their claim processing software.
- These rejections can provide important insight to payer specific guidance for clean claims.
  - Incorrect claim filing indicator
  - Payer specific requirements for electronic claim form
  - Duplicate Claim

Revenue Cycle – Back End

Claim Transmissions – Paper Claims

- There are only two instances where your office should be sending claims to the insurance company on paper.
    - The insurance company does not accept electronic claims or do not have an electronic payer ID.
    - The insurance company requires reconsideration and/or appeals to be sent in on a CMS-1500 claim form with necessary documentation to support the reconsideration or appeal.
- If your practice is sending out paper claims for any reason other than the above-mentioned reasons, evaluate your processes and set all claims to go in an electronic format if possible.

Revenue Cycle – Back End

Claim Transmissions – Other Methods

- Some payers allow or even require claims to be transmitted by other means other than electronically through a clearinghouse or via paper (CMD-1500 claim form).
- Some insurance companies have their own claim filing portals available on their websites or via a provider portal.
- If a payer does not accept electronic claims via a clearinghouse, check with that payer to see if they require or allow claims transmission via their own portal.
- One example of this might be a state Medicaid program. Many state Medicaid programs require their claims be filed online via their own portal or website.

Revenue Cycle – Payment Posting

Electronic Remittance Advices (ERAs)

Set up electronic remittance advices and electronic funds transfers (ERA's/EFT's) with payers when possible.

An electronic remittance advice, or ERA, is a process by which the payer sends the claim payment information to your clearinghouse. Your practice management software can "pull" the claim payment information from the clearinghouse and automatically post each payment to the corresponding encounter in your PM system. This process can save your staff valuable time when compared with manually posting each payment in a remittance advice or explanation of benefits (EOB).

Revenue Cycle – Payment Posting

Electronic Remittance Advices (ERAs)

To make the automated payment posting process even more efficient, your practice should:

- Establish automatic small balance write off amounts. This will save time cleaning up small balance accounts.
- Enter payer contracts and fee schedules into your practice management system if available.
    - Set alerts within the system to identify any payment that does not reflect the contracted allowable for each insurance company or payer.
    - Set alerts to identify any claim with a non-payment/zero payment or partial payment as well
- The billing staff will need to work any exception report or payment discrepancy report generated by the ERA process

Revenue Cycle – Payment Posting

Manual Posting

Not all payments coming into the practice are able to be electronically or automatically posted to your practice management system. These include:

- Insurance payments and EOBs that are delivered via mail
    - Medicare Supplemental insurance policies are a good example
    - Small plans that are not set up to transmit ERA's
- Patient payments
    - One way to cut down on the number of patient payments coming through the mail is to make a payment portal available on your website or through your patient portal.

Revenue Cycle – Denials

Denial Management

- One of the most important elements in revenue cycle management is identifying, correcting and tracking claim issues. It is vital to make sure that the following claim delays are monitored, worked and tracked to ensure clean claim submission and prompt payment.
    - Under payments or partial payments
    - Denials
    - Delays
    - Return Mail
    - Insurance takebacks / refunds

Revenue Cycle – Denials

Denial Management

- While managing the revenue cycle, some percentage of claims will be denied by the insurance carrier. It is critically important that denials are worked as soon as possible, and any trends that are leading to denials are identified and rectified on the front end.
- The aim is to reduce the number of denials as much as possible, and then to address denials as quickly as possible to avoid them building up or being set aside.
- Our recommendation and best practice is to work denials while payments are being posted. Yes, this slows down payment posting a bit, but in the long run, improves efficiency and ensures denials don't get lost in the pile of "work to get to."

Revenue Cycle – Denials

Denial Management

A claim denial is different from a claim rejection. A claim denial made it through the edits of the practice management system, the clearinghouse and the edits built into the payer's software. These claims have been processed by the insurance company and a reason found for them not to pay the claim.

Revenue Cycle – Denials

Denial Management

- Denials can vary widely and are very often payer specific.
- Some examples of claim denials are:
    - Missing / invalid referring provider information
    - Duplicate of previously processed claim
    - Service not covered by plan benefit
    - Prior authorization required, none on file
    - Patient not covered / no benefits at time of service
    - Facility or provider out of network
    - Care is covered by another payer
    - Missing information to process claim

Revenue Cycle – Denials

Denial Management

- If your staff can not understand the denial reason from the remark code on the EOB or ERA, make sure they call the insurance company for further explanation.
- Claim denials should NEVER be written off without a full understanding of the reason for the non-payment.
- Can you run denial reports from your practice management computer system? This can be very tricky, and in some systems impossible. If you have the capacity to configure the system to give you meaningful reporting on denials, do that. The more information you have at hand to combat denials, the better.

Revenue Cycle – Denials

Denial Management

- Do not just correct these claims and move on!
- Have your billing staff make note of the denial reason. Track denials by payer and reason, looking for patterns in the denials. Have your biller / payment poster / revenue cycle specialists share this information with the revenue cycle manager or billing supervisor so that the entire staff, from the clinical staff to the billing staff, can be aware of payer specific claim filing guidelines. Making note of these guidelines for future claims can ensure clean claims go out the first time, reducing rejections and denials, and gets you paid faster!

Revenue Cycle – Denials

Denial Management

- This “feedback loop” is vital to ensure clean claims are filed. This will ensure prompt payment and save you money and your staff time by reducing the number of claim denials your office receives. A claim denial takes time to work and usually requires payer specific reconsideration or appeal forms be submitted along with medical records or additional documentation.

Revenue Cycle – Other

Under or Partial Payments

- Insurance underpayments or partial payments is an area that is often overlooked or not managed well. This is especially true with electronic remittance advices.
- When a payment automatically posts to your practice management system, it is important to periodically or spot check to ensure that payments received and posted to your system are the contracted rate.
- Ensuring that the insurance company paid the claim accurately and according to your contracted rate is a vital step that is sometimes overlooked.

Revenue Cycle – Other

Under or Partial Payments

- One way to ensure the payments you receive are accurate and paid according to your contracted rate, is to build, update and maintain an insurance payer fee schedule or allowables table.
- An allowables fee schedule generally lists your top-billed CPT codes as well as your top 10 to 20 insurance carriers.
- You can keep these “allowable amounts” on a spreadsheet. Many practice management systems will allow you to upload the allowables to the system as well.

Revenue Cycle – Other

Uploading a Fee Schedule

- If you choose to upload the allowables to your practice management system, you can take it a step further by setting alerts within the system when a payment posts for less than the allowable amount you have entered in the practice management system.
- Check with your practice management software vendor to see if your system has the capability to set up your insurance allowables.
- We'll speak more about this later.

Revenue Cycle – Other

Claim Delays

- As previously mentioned, claim denials are one type of claim delay.
- If you and your staff are not sending out a clean claim the first time, you are costing yourself valuable time and money by having to “work” these denials and resubmit them for proper adjudication and payment.
- Do whatever you need to do to get to the source of claims not going out clean the first time and remedy the issue.

Revenue Cycle – Other

Claim Delays

Another form of claim delay is insurance payers requesting records for a pre-payment audit.

Your billing staff needs to track these requests for records. Look for patterns. If a particular payer ALWAYS requests records for a specific CPT code, consider sending the records in with the claim when it is initially filed.

Although filing a paper claim can take longer to process than an electronic claim, you are saving time and work by your staff by providing the records at the time of claim submission rather than letting the insurance company wait until close to the "clean claim" payment deadline (in your contract) and then request the records so they can hold the claim up an additional 30 – 60 days while they "review" it.

Revenue Cycle – Other

Return Mail

- Delays in processing return mail can cause a delay in payment reaching you.
- Have a process in place, one with very clear instructions, so your staff knows how to handle, and process return mail.
- Return mail mostly applies to patient statements being returned for a bad address, but it can apply to insurance companies as well, especially secondary payers you send paper claims to.
- Although it seems trivial when compared to making sure your primary payers receive and process claims, working your return mail is just as important.
- If your patients are not receiving statements, it is very difficult to get them to pay the bill! ;)

Revenue Cycle – Other

Return Mail

- Depending on how your office sends out patient statements will determine what tools are available to you to help manage returns.
- If you use a third-party company to send out your statements, they may have the ability to find and forward the statement to the proper address and supply you with a report so you can make the corrections in your practice management software. Check with your third-party company to see what reports are available for you to use for return mail.
- If you manually send out statements from your office, the process for tracking down the correct address for a patient may be more manual and time consuming for your staff.

Revenue Cycle – Other

Return Mail – Medicare Specific

- If Medicare sends the practice mail and the item sent by Medicare is returned, Medicare will shut down the practice for Medicare claims. While generally, the funds are recoverable, it causes a big delay and extra work for the staff.
- Make sure the address has is the right for the practice, and that address is being monitored!

Revenue Cycle – Other

Recoupments/Refunds

- The most common way for an insurance company to recoup money paid in error, or what they believe to be in error, is automatic recoupment of the money by offsetting future payments on an ERA.
- This method can be convenient if the insurance company is truly entitled to a refund as it will save time and money by not having to issue a paper check and mail it to the insurance company.
- However, it is very important that any request for a refund or recoupment notice be properly investigated as the insurance company does not always have a valid reason for requesting the funds back.

Revenue Cycle – Other

Recoupments/Refunds

- An insurance company will typically give the provider a set amount of time from the notice of the refund request or recoupment notice and the actual “takeback” of the funds.
- If you do not feel the refund request is valid you must send notice to the insurance company appealing the recoupment. Time is of the essence in these circumstances where you do not agree with the refund request or recoupment notification as you will usually only have 30 days to respond to the notice.

Revenue Cycle – Other

Accounts Receivable Follow Up

- Monitoring you're A/R is vital to ensuring you are paid for services you furnish to patients. Working outstanding unpaid claims is vital to a healthy practice. If your practice does not have a method for working outstanding / unpaid claims, it will impact the financial health of your practice.
- In theory, by working rejected and denied claims as soon as they are received, your outstanding AR should be kept at a minimum. Catching claim issues when they happen will lessen the number of outstanding claims in the later aging buckets.
- However, denials and rejections do get missed and even when they are worked, can sit in your aging for several days and even months before the insurance company will process your reconsideration or appeal. It's critical to be on top of the A/R!

Revenue Cycle – Other

Accounts Receivable Follow Up

- There are many different methods available within practice management software packages that allow you to customize monitoring the A/R in a way that works best for you, your employees and your practice, and it all starts with reporting. You'll need solid reporting to track outstanding A/R.
- Many practice management systems have sophisticated work queue functionality that can be set up with rules so that your follow up team is working the claims in the order that you want them working. Check your system to see what's available.
- When we discuss reporting, we'll look at the different kinds of reports you can run to best manage the outstanding A/R.

Staffing

The Fundamentals

- Unless you are outsourcing your revenue cycle work, the work is being done entirely by your staff. Ensuring they are set up to win and be maximally effective is key. To effectively deploy and manage your staff, and to have them best set up to be successful, you must have these pieces in place minimally:

  - Job Descriptions
  - Written Procedures
  - Expectations Established
  - Performance Monitoring
  - Periodic Evaluations

Staffing

Job Descriptions

- Job descriptions lay the groundwork for the success of your employees and your practice.
- When hiring new employees, it is important to have a detailed description of the job they will need to perform so you can set clear expectations for them from day one. Most employees work best when they have a clear understanding of the job they have been hired to perform.
- When dealing with an unhappy employee, or a good employee who leaves the practice for a different job, one of the most common reasons is them employee indicates that “this is not the job I was hired to do.”
- When an employee is hired with a clear understanding of the job he/she will be performing, they are more likely to be successful and satisfied in their job, and you will be more likely to retain that employee.

Staffing

Written Procedures

- Much like well defined job descriptions, clear and concise written job procedures are a building block for having happy, effective and efficient employees.
- With the ever-changing world of healthcare, having and maintaining written procedures for each of the positions in your practice can feel overwhelming and impossible to keep up with. But providing your employees with the procedures necessary to complete their jobs will ensure success of not only your employees but of your practice.

Staffing

Written Procedures

- Written procedures for the positions in your practice tend to fall into that category of “when we have time” or “I will get to that later”, but they are so vital to your practice efficiency it is worth the time invested to make sure they are correct and up to date.
- Written procedures also help with evaluating your staff to ensure they are doing their job correctly and efficiently. This can be used to encourage employees who are struggling or underperforming to be counseled and offered the education necessary to perform their job to the expected standard set by your practice.

Staffing

Setting Expectations

- Written procedures for the positions in your practice tends to fall into that category of “when we have time” or “I will get to that later”, but they are so vital to your practice efficiency it is worth the time invested to make sure they are correct and up to date.
- Written procedures also help with evaluating your staff to ensure they are doing their job correctly and efficiently. This can be used to encourage employees who are struggling or underperforming to be counseled and offered the education necessary to perform their job to the expected standard set by your practice.

Staffing

Communication

- Our mantra is more communication is better!
- We cannot say enough about how important communication is for the health of the practice. While it may not seem directly related to revenue cycle management, it is.
- If your staff has the sense that they can be fully in communication with you about any issue that arises, you can work out virtually any problem with managing the revenue cycle. If your staff is in any way hesitant, or has any fear, of bringing "bad news," they are more likely to hide things or stay silent until issues spin badly out of control.
- It is up to you to create an environment of communication, and to understand and appreciate that you'll have to continue to foster that environment.

Staffing

Communication

- Communication with employees regarding the expectations of the providers, supervisors, managers, etc. is vital to ensure excellent performance from your staff.
- As previously mentioned, job descriptions and written procedures are a good place to start to set expectations for your employees.
- An environment of clear and open communication is vital so that your staff stays aware of what is expected of them. This is challenging and is especially difficult with a large staff or multiple locations.

Staffing

Communication

- Lines of communication should be established that works best for your practice size and the number of locations.
- In a small, single location practice, setting up formal communication structures or meetings may not be necessary, while in a large practice with multiple providers and multiple locations, it is a necessity to formalize communication structures.
- What's critical is that employees have the experience of being in communication, that their needs are being heard, and that they fully understand what is expected of them.

Staffing

Monitoring Performance

- It is important that you are monitoring the performance of your staff and that your staff knows their performance is being monitored. It's also important that what is being monitored is consistent with what is expected of them and that it is possible to objectively measure what's being monitored.
- For example, you can monitor and measure how often a co-pay is not collected at time of service, or what the average number of days between date of service and when a claim is first billed.
- Monitoring the performance of your staff in the areas that impact the revenue cycle is critical to having a healthy practice. It is up to you to determine what you're going to measure, and then to do it reliably.

Staffing

Periodic Evaluations

- Having regularly scheduled evaluations, and sticking to the schedule, is an important aspect of managing your staff and for ensuring that the revenue cycle work is being done consistent with your expectations.
- Generally, for new hires, a 90-day probation period with a formal evaluation after the completion of the 90-day period, and for all staff, and annual review is a good rule of thumb.
- At the same time, if issues arise that need immediate attention, addressing those as they arise, like addressing denials as they come in, is important in keeping the practice running smoothing and the revenue cycle well-managed.

Patient Satisfaction

Patient satisfaction is rarely included when discussing your revenue cycle. However, in today's world with many care options available to patients, maintaining patient satisfaction is the lifeblood of your practice's revenue cycle. If patients choose the provider down the street over you practice due to patient dissatisfaction, your revenue cycle will be greatly impacted.

We will discuss:

- Maximizing the Patient Experience in Your Practice
- Patient Financial Experience
- Patient Satisfaction Surveys and Online Reviews

Maximizing the Patient Experience in your Practice

Patient satisfaction (or dissatisfaction) begins before the patient even walks through the door. It starts with the greeting they receive on the telephone when they call to schedule an appointment, followed by the greeting they receive from your front desk staff when they walk through the door, the friendliness of your workup staff, followed by the interaction with the physician, then checking out and scheduling the next appointment, and finally receiving a bill in the mail.

Throughout the course of the day, especially when your clinic is running behind, it can be difficult to take the time to slow down and give each patient the attention he or she may require.

Patients want:

- To be listened to
- Communicated with in a way they can understand
- To be treated respectfully
- Quality healthcare
- Positive health outcomes

Patient Financial Experience

There are numerous paths to patient satisfaction, but one factor is increasingly clear: practices must focus as much attention on the patient financial experience as they do the clinical experience. A patient's experience with the clinical staff and the physician can be very positive, but if the financial experience is dissatisfactory, that can have an impact on the likelihood of the patient to return as well as to share the negative experience with others.

Tips to effectively communicate with patients their financial exceptions and obligations:

Have clear patient financial policies in place. Some examples of policies that need to be communicated to patients are:

- Will the copay be due prior to being seen by the physician?
- Will a surgical deposit be required prior to scheduling surgery?
- If the patient has had a previous account turned to collections or written off to bad debt, will they be required to pay this previous balance in full prior to scheduling an appointment?

Patient Financial Experience

- Communicate financial obligations prior to the appointment if possible
  - Consider having a dedicated staff member to call patients prior to their appointments who will owe more than $100 (or other amount you determine) at the time of service, or who have an outstanding balance you will attempt to collect at the visit. This allows patients who may not be able to pay at the time of the appointment the embarrassment of having to reschedule due to a payment issue in front of a lobby full of people.
- Be patient with your patients.
  - Medical bills can be confusing, try to explain financial obligations in a way your patients can understand. When a patient doesn't understand a bill, they can become frustrated (and even hostile) with your staff. Maintain your patience as you try to explain the financial obligation to the patient.
  - Maintain financial transparency. If your staff has made an error, admit to it, apologize and fix the issue. Thank the patient for pointing out the error so it can be corrected.
- Allow for financial hardships.
  - Include a process in your financial policies for patients to apply for hardship exceptions.

Patient Satisfaction Surveys

Patient feedback is vital to ensure you and your staff are meeting patient expectations and leaving patients satisfied with the care, as well as the customer service, they received from your clinic.

- There are several survey software platforms now available to request a patient complete a satisfaction survey
  - Email a link to the survey after the patient completes the visit
  - Supply a link on your practice website
  - Furnish a QR code on appointment cards or marketing material
  - Hand the patient a paper survey prior to checking out. (However, I don't recommend this as most of the surveys will end up in your lobby trash).
- Share positive survey comments on your website (with the patient's permission).

Online Reviews

- In our current age of technology, more patients use the internet to find a healthcare provider.
- Patients look more to online reviews when deciding what healthcare provider to see.
- Customer service and financial experience, not clinical skills, predominately lead to the distinction between high rated and low rated doctors online.
- What can you do?
  - Ensure your staff, all staff, understand the importance of online reviews and the impact on your business.
  - Encourage patients who express satisfaction with their visit to leave an online review.
  - Offer the patient a list of website addresses they can visit to leave a positive review.
  - Supply links to websites where a positive review can be left on your practice website.
  - Send patients an email with the links to the websites where they can leave a positive review.

Reporting

"Noticing is nice, measuring is better."

Reporting


DILBERT By Scott Adams
DO YOU WANT THE DETAILED ANALYSIS YOU WON'T UNDER-STAND...
OR THE EXECUTIVE SUMMARY THAT IS DANGEROUSLY MIS-LEADING?
I WANT AN EXECUTIVE SUMMARY THAT IS NOT MISLEADING.
I'LL COUNT ON YOU NOT KNOWING THE DIF-FERENCE.
@ScottAdamsSays
Dilbert.com
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4-11-16

Reporting

General

- You cannot effectively manage what you cannot measure. Said another way, you cannot tell what direction you need to go if you don't know where you are!
- Having accurate and complete data of what is happening in the practice is essential for you to effectively manage the revenue cycle. Knowing how to generate the reports necessary from your practice management system and understanding what the data is telling you is critical aspect of your job.
- Being able to analyze your data with at the very least a minimal level of expertise with using data analysis tools like MS Excel is necessary. It's also important to understand how to pull reports from your practice management system so that you can do cogent analysis.

Reporting

Types of Reports – some examples

- Operational
  - Charge-capture
  - Accounts Receivable – both carrier and patient
  - Lag (DOS-DOE, time to resolution)
  - Cash controls (batching and balancing)
- Management
  - AR/Days in AR
  - Productivity – both staff and physician
  - Reimbursement Analysis
  - Future Missed Business

Reporting

Operational Reports – Charge Capture

- Are all charges for clinical services provided being captured? If charges are being lost in the process, revenue is clearly negatively impacted. You must have some method for ensuring that every charge is recorded in the practice management system. Most modern systems have some report or reports that tie charges to the schedule of appointments. This way, any appointment that has no associated charge is reported on.
- To have this report be useful, you need to keep the appointment calendar up to date. We recommend running this report at a minimum monthly, and if there are operational issues, weekly or even daily.

Reporting

Operational Reports – Charge Capture

Missed Visits

Practice ABC Eye Specialists

Date ranges 1/1/2021 to 9/30/2021
All Provider Profiles
All Groups

Appt Time	Chart #	Patient Name	Provider Profile	Appointment Type	Visit #
2:00PM	50543			NEW PATIENT COMPLETE	11517076
2:15PM	49439			FOLLOW UP	11521867
2:30PM	43961			ESTABLISHED PATIENT COMPLETE	11521545
3:00PM	49400			FOLLOW UP	11519719
3:15PM	40475			ESTABLISHED PATIENT COMPLETE	11499921
4:00PM	50535			NEW PATIENT COMPLETE	11516981

Total missed visits for 09/27/2021: 24

Date: 09/28/2021

7:45AM	44573			PHACO W/IOL	11519893
8:30AM	41196			PHACO W/IOL	11519899

Reporting

Operational Reports – Accounts Receivable

- Accounts receivable is a measure of charges that have not been fully paid, either by a carrier or a patient. A good, modern system will allow you to order your accounts receivable reports in a variety of ways so that you can best analyze the AR.
- Some of the different ways to view the AR:
  - Total AR
  - Total Carrier AR
  - Total Patient AR
  - AR by aging bucket
  - AR by aging bucket by Carrier
  - Detailed AR by Carrier
  - Detailed AR by Patient

Reporting

Operational Reports – Accounts Receivable

- Total AR is the sum of all outstanding unpaid or partially unpaid charges. This is a very useful, high-level measurement when compared to previous months. When taken in conjunction with other measures, it can indicate the relative health of a practice. When looking at this measure, it is also important to separate this into patient and carrier total AR, as this can point at different issues the practice may be experiencing.

Reporting

Operational Reports – Accounts Receivable

Key Indicators - A/R Summary By Month

Mo / Year	Beginning A/R	Charges Posted*	Payments Posted	Adjust. Posted	Changes In A/R	Ending A/R**
Aug-21	$179,903	$281,966	$187,281	$93,276	$1,410	$181,313
Jul-21	$204,225	$308,437	$223,919	$108,840	($24,322)	$179,903
Jun-21	$177,123	$329,818	$194,921	$107,796	$27,101	$204,225
May-21	$183,415	$290,740	$194,753	$102,279	($6,292)	$177,123
Apr-21	$179,110	$291,278	$193,071	$93,903	$4,305	$183,415
Mar-21	$181,289	$343,832	$226,767	$119,244	($2,179)	$179,110
Feb-21	$178,548	$275,350	$173,074	$99,535	$2,741	$181,289
Jan-21	$153,788	$249,744	$145,207	$79,777	$24,760	$178,548
Dec-20	$145,000	$250,438	$157,875	$83,774	$8,789	$153,788
Nov-20	$120,262	$246,677	$147,923	$74,016	$24,738	$145,000
Oct-20	$166,317	$251,454	$190,508	$107,001	($46,056)	$120,262
Sep-20	$162,965	$327,138	$198,932	$124,854	$3,352	$166,317
Aug-20	$165,278	$305,350	$196,946	$110,716	($2,313)	$162,965
Jul-20	$146,275	$291,128	$172,898	$99,226	$19,004	$165,278

Reporting

Operational Reports – Accounts Receivable

- AR by aging bucket is useful to see how well the charges are being collected over time. When looking at this report, it is critical to order the data so that you are seeing a true reflection of the operations. For example, if you order the data by date of service, and there are delays in getting the charges “out the door”, the results may be misleading. Likewise, if you order the data based on date of billing, it can skew the data tremendously and make it look much better than it is. Some systems allow you to order the data based on data of aging (or some similar metric). If that is not available, favor AR reports based on date of service.

Reporting

Operational Reports – Accounts Receivable

Typically, when reviewing accounts receivable in aging buckets, you'll be looking at three things:

- The overall trend. Are balances marching across? If so, claims are likely not going out cleanly and the follow up work is not being effective.
- The total % open over 90 days. A solid benchmark is under 15% total in the over 90-day buckets. This is healthy, and the lower the better with one major caveat we'll address later.
- The total % in the current and 31–60 day buckets. A solid benchmark here is above 80%, with the over 75% in the current bucket. This tells you claims are being processed fast, with the vast majority being paid first time out.

Reporting

Operational Reports – Accounts Receivable

Examples of AR reports. First one is very healthy, second – not so much!

Current	31-60	61-90	91-120	121-150	151+	TOTAL
$500,000	$120,000	$27,000	$13,000	$3,500	$7,800	$671,300
74.48%	17.88%	4.02%	1.94%	0.52%	1.16%	100.00%

Current	31-60	61-90	91-120	121-150	151+	TOTAL
$500,000	$250,000	$210,000	$170,000	$120,000	$395,000	$1,645,000
30.40%	15.20%	12.77%	10.33%	7.29%	24.01%	100.00%

Reporting

Operational Reports – Accounts Receivable

- Generating reports that show you the AR by bucket by carrier is exceptionally useful to identify troublesome carriers. When generating this report, there are a couple important things:
  - Have the report show you the total dollar amounts open. You may have a carrier with a very high percentage open over 90 days, but the total dollar amount in incidental.
  - Have the percentage by bucket calculated at the carrier level, not the total level. This way you can easily see what carriers are healthy and which are not.

Reporting

Operational Reports – Accounts Receivable

Code	Carrier Name	Current	30 Days	60 Days	90 Days	120 Days	Total	Current	30 Days	60 Days	90 Days	120 Days
		$141,016	**$13,248**	**$8,250**	**$691**	**$4,591**	**$167,796**					
		84%	**8%**	**5%**	**0%**	**3%**	**100%**					
MCR	MEDICARE	$78,732.38	$47.96	$784.00	$0.00	$0.00	$79,564.34	99%	0%	1%	0%	0%
	NOT BILLED YET	$26,560.00	$0.00	$0.00	$0.00	$0.00	$26,560.00	100%	0%	0%	0%	0%
AARP1	UHC AARP MEDICARE COMPLETE	$2,670.00	$9,011.00	$2,907.00	$0.00	$1,787.98	$16,375.98	16%	55%	18%	0%	11%
CHRO1	CHRONIC DISEASE FUND	$5,766.73	$730.26	$0.00	$0.00	$0.00	$6,496.99	89%	11%	0%	0%	0%
UHCMCR	UHC MEDICARE SOLUTION	$5,409.00	$0.00	$0.00	$0.00	$0.00	$5,409.00	100%	0%	0%	0%	0%
UNIT2	UNITED HEALTHCARE .	$1,953.97	$2,917.00	$0.00	$0.00	$0.00	$4,870.97	40%	60%	0%	0%	0%
MAR02	MARTINS POINT HEALTH CARE	$4,211.00	$0.00	$0.00	$0.00	$0.00	$4,211.00	100%	0%	0%	0%	0%
MER01	MERITAIN HEALTH	$0.00	$0.00	$2,997.00	$0.00	$0.00	$2,997.00	0%	0%	100%	0%	0%
REGE1	REGENERON EYLEA	$2,017.07	$0.00	$0.00	$0.00	$0.00	$2,017.07	100%	0%	0%	0%	0%
AETNA MCR	AETNA MEDICARE	$2,000.00	$0.00	$0.00	$0.00	$0.00	$2,000.00	100%	0%	0%	0%	0%
AAR01	AARP	$1,495.70	$0.00	$0.00	$0.00	$0.00	$1,495.70	100%	0%	0%	0%	0%
BPA01	BENEFIT PLAN ADMINISTRATORS	$0.00	$0.00	$0.00	$0.00	$1,440.20	$1,440.20	0%	0%	0%	0%	100%
HEA01	HEALTH PLANS INC	$999.00	$200.00	$0.00	$0.00	$0.00	$1,199.00	83%	17%	0%	0%	0%
BCMA	BLUE CROSS BLUE SHIELD OF MA	$807.09	$0.00	$0.00	$390.98	$0.00	$1,198.07	67%	0%	0%	33%	0%
UNI02	UNITED HEALTHCARE GA	$763.00	$0.00	$206.07	$0.00	$0.00	$969.07	79%	0%	21%	0%	0%

Reporting

Operational Reports – Accounts Receivable

- Finally, when managing the AR, you want to look at a detail level – typically only focusing on what is open over a certain number of days – often 90 days. This allows you to see how old is old. An open charge may be 3 years old, but still only in the 120+ bucket. You can also see if you have large clumps of money with a single patient – that may be a different sort of issue you need to manage.
- This can be ordered by carrier or by patient balance. The results here give you very different potential issues to manage!

Reporting

Operational Reports – Accounts Receivable

Patient Chart Number	Visit Primary Carrier Name	Visit Secondary Carrier Name	Service Date	Service Year	Charge Code	Charges	Adjustments	Insurance Payments	Insurance Balance
21519	MEDICARE - MEDICARE PART B	HHP01 - HOMETOWN HEALTH PLAN	1/4/2021	2021	92250	$138.00	$97.43	$32.55	$8.02
21519	MEDICARE - MEDICARE PART B	HHP01 - HOMETOWN HEALTH PLAN	1/4/2021	2021	99214	$267.00	$132.99	$51.56	$82.45
58232	HSB01 - HEALTH SCOPE BENEFITS	N/A - N/A	1/4/2021	2021	99204	$308.00			$308.00
39887	MEDICARE - MEDICARE PART B	NVMD1 - Medicaid	1/4/2021	2021	J0178	$8,000.00	$4,312.98	$2,949.62	$737.40
57047	BCBSF - BLUE CROSS FEDERAL EMPY PROGM	N/A - N/A	1/4/2021	2021	92250	$138.00		$0.00	$138.00
57047	BCBSF - BLUE CROSS FEDERAL EMPY PROGM	N/A - N/A	1/4/2021	2021	99213	$134.00		$0.00	$94.00
58058	MEDICARE - MEDICARE PART B	AETNASU2 - AETNA (TPA) MEDICARE SUPP CLAIMS	1/4/2021	2021	67028	$745.00	$626.85	$94.80	$23.35
58058	MEDICARE - MEDICARE PART B	AETNASU2 - AETNA (TPA) MEDICARE SUPP CLAIMS	1/4/2021	2021	J9035	$110.00	$34.25	$60.60	$15.15
41371	PHPMC - MEDICARE PROMINENCE HEALTH PLAN	GOOD1 - GOOD DAYS	1/4/2021	2021	J0178	$4,000.00	$2,143.52	$1,486.03	$280.40
34914	GEHA2 - GEHA-ASA	E4UCP - EYLEA 4 U COPAY PROGRAM	1/4/2021	2021	J0178	$4,000.00	$1,780.00	$1,037.16	$1,182.84
26961	NVMD1 - Medicaid	N/A - N/A	1/4/2021	2021	J0178M2	$4,000.00		$0.00	$4,000.00
54343	MEDICARE - MEDICARE PART B	NVMD1 - Medicaid	1/4/2021	2021	67028	$1,490.00	$1,313.60	$85.83	$90.57
54343	MEDICARE - MEDICARE PART B	NVMD1 - Medicaid	1/4/2021	2021	92012	$152.00	$60.28	$0.00	$91.72
54343	MEDICARE - MEDICARE PART B	NVMD1 - Medicaid	1/4/2021	2021	92134	$118.00	$76.15	$0.00	$41.85
54343	MEDICARE - MEDICARE PART B	NVMD1 - Medicaid	1/4/2021	2021	J0178	$8,000.00	$4,312.98	$2,949.62	$737.40
57737	HHPMC - MEDICARE SCP	N/A - N/A	1/5/2021	2021	67028	$745.00		$0.00	$745.00
11378	MEDICARE - MEDICARE PART B	BCBSF - BLUE CROSS FEDERAL EMPY PROGM	1/5/2021	2021	92012	$152.00	$60.28	$0.00	$91.72
11378	MEDICARE - MEDICARE PART B	BCBSF - BLUE CROSS FEDERAL EMPY PROGM	1/5/2021	2021	92134	$118.00	$76.15	$0.00	$41.85
56163	UEHW1 - ELECTRICAL WORKERS HEALTH & WELFARE	E4UCP - EYLEA 4 U COPAY PROGRAM	1/5/2021	2021	J0178	$8,000.00	$2,901.40	$4,159.77	$938.83
28936	MEDICARE - MEDICARE PART B	AMESU - AMERICAN NATIONAL INS COMPANY	1/5/2021	2021	92134	$118.00	$76.15	$0.00	$41.85

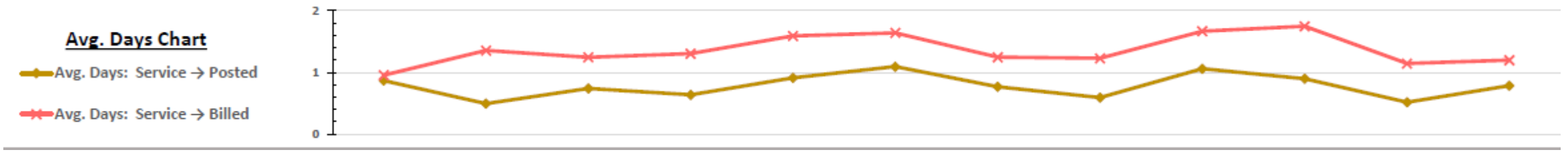
Reporting

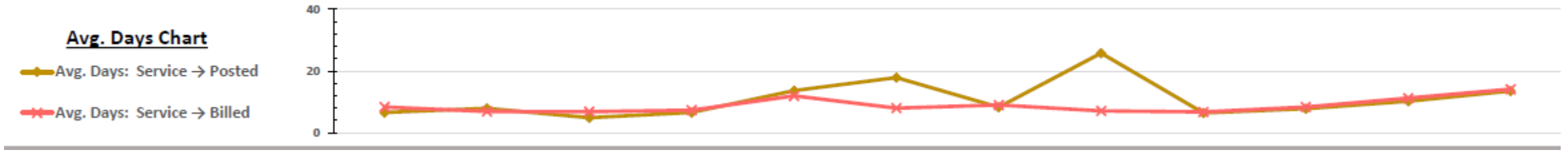
Operational Reports – Lag Reports

- If you're practice management system can report on it, a very useful set of data to look at is
  - Time from date of service to date posted
  - Time from date of service to date billed
- This data can point at issues you may have in the process of getting charges submitted. On the next slide are two graphs that show this data over time – one from a healthy practice, and one from a not so healthy practice.

Reporting

Operational Reports – Lag Reports





Reporting

Operational Reports – Batch Controls

- Making sure that money collected at time of service is accounted for and balances at the end of the day is critical for effectively managing the revenue cycle. While the money collected at time of service is generally a very small percentage of the practice, keeping track of it is a key piece of staff effectiveness and management. If the staff knows that every dollar is being accounted, any unwanted temptation can be headed off.
- Most modern practice management systems will allow for multiple batches to be open during the day, and requiring all batches closed at the end of the day will allow you to match what was collected and what is in the batch reports. This should match what is deposited to the bank.

Reporting

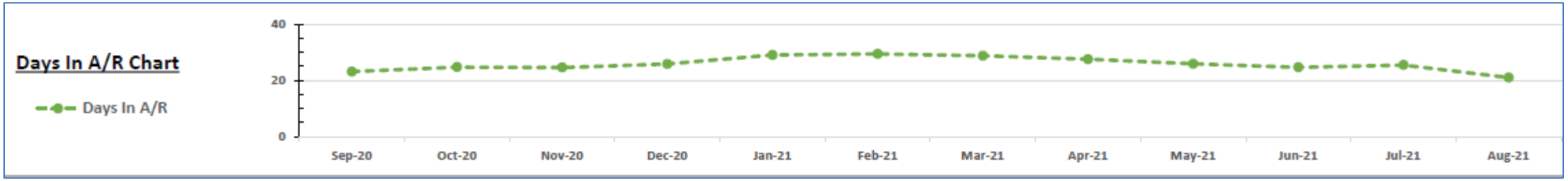
Management Reports – Days in AR

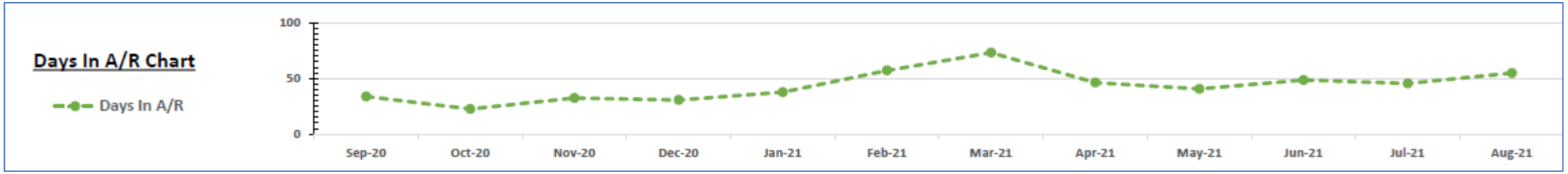
- Days in AR (accounts receivable) is a calculation for ascertaining approximately how long on average it takes to collect on your charges. This data is best looked at in two ways:

  - Making sure the value is within a “healthy” range – not too high or two low.
  - It is consistent over time.

Reporting

Management Reports – Days in AR





Reporting

Management Reports – Physician Productivity

- Reporting on physician productivity is extremely useful for analyzing how profitable the practice is. Productivity can be looked at in several ways. Minimally, you want to know

  - What is the mix of services being provided by the providers?
  - How many patients is a provider seeing on any given day in clinic?
  - What is the $ volume of charges and payments generated by a provider per month?

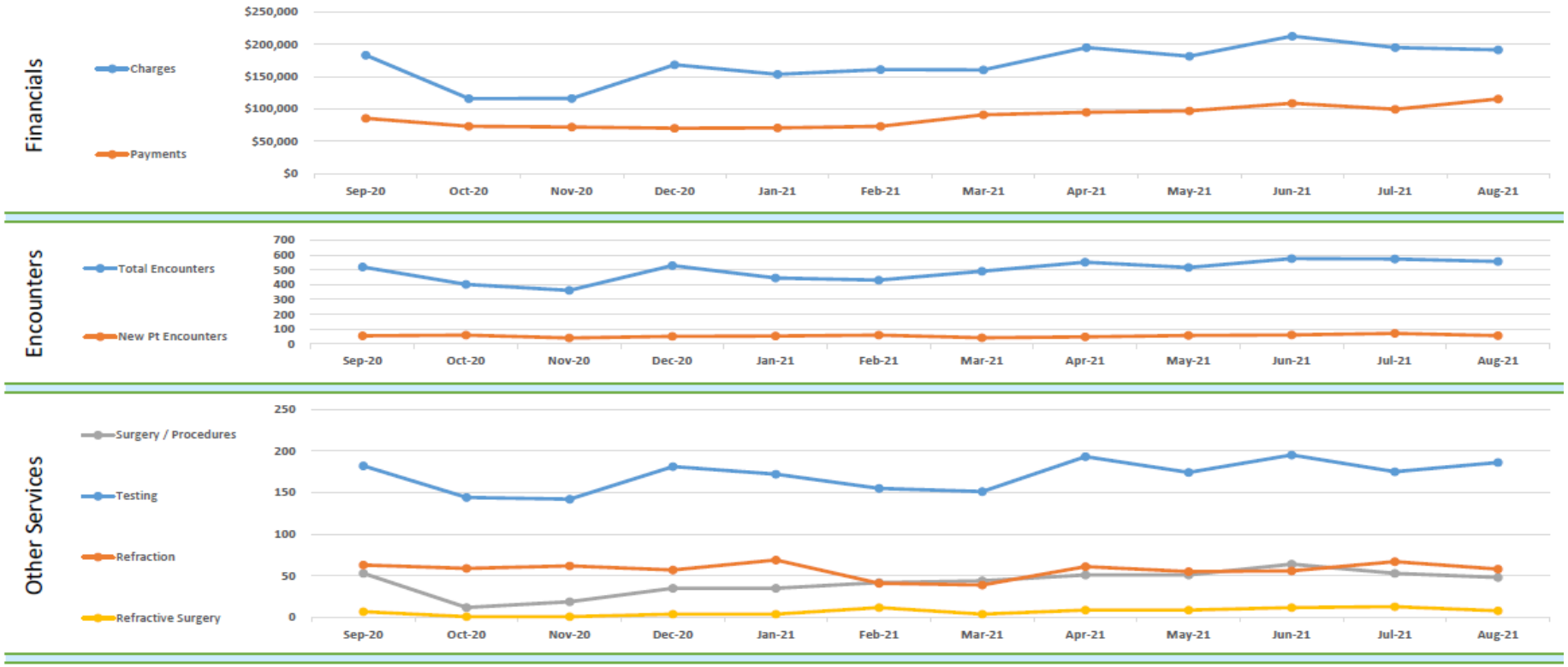
Reporting

Management Reports – Physician Productivity

Financials	Average	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Charges	$169,506	$183,131	$116,113	$116,158	$168,458	$153,562	$160,963	$160,408	$195,024	$181,483	$212,588	$194,800	$191,384
Payments	$87,700	$85,504	$73,164	$72,198	$70,302	$70,720	$73,219	$91,146	$94,928	$97,223	$108,774	$99,642	$115,579
Encounter Counts	*Encounter: single Pt on single Date of Service, regardless of # Services provided. | New Pt Encounter: an encounter with at least 1 New Pt Visit Code*												
Total Encounters	495	518	401	361	528	445	430	490	551	515	575	572	556
New Pt Encounters	55	55	60	41	52	54	60	43	48	58	61	72	57
% New vs Total Encounters	11.1%	10.6%	15.0%	11.4%	9.8%	12.1%	14.0%	8.8%	8.7%	11.3%	10.6%	12.6%	10.3%
Services By Category													
Surgery / Procedures	42	53	12	19	35	35	42	44	51	51	64	53	48
Testing	171	182	144	142	181	172	155	151	193	174	195	175	186
Refraction	57	63	59	62	57	69	41	39	61	55	56	67	58
Refractive Surgery	7	7	1	1	4	4	12	4	9	9	12	13	8

Reporting

Management Reports – Physician Productivity



Reporting

Management Reports – Reimbursement Analysis

- It's important for managing the revenue cycle to review reimbursements on a periodic basis. there are many ways to look at this to get a complete and accurate picture of the health of the practice from the perspective of reimbursements. Minimally, on a regular basis, review:

  - The % of charge $ amount that has been fully adjudicated after 6 months. This should be at least 95% and preferably closer to or above 99%.
  - Are there charges being paid at 100% of the charge amount?
  - How many charges were written off at 100%?

Reporting

Management Reports – Missed Future Business

Having some method of tracking patients that have been for a visit that do not have a follow up appointment or recall set is essential for maximizing practice revenue. This is a clip from a report we provide our clients:

Created: September 21 — Data thru: August 2

Missed Future Business

This is a list of all patients whose previous appointment was last month and do not have a future appointment or a recall in the system

#	Chart#	Last Appt Date	Appointment Type	#	Chart#	Last Appt Date	Appointment Type	#	Chart#	Last Appt Date	Appointment Type
1	000000009034	Aug 2	COMPLETE/NEW	51	14339	Aug 12	NEW PATIENT LONG	101	000000003782	Aug 25	POST OP
2	14263	Aug 2	EMERG VISIT NEW	52	000000038534	Aug 13	COMPLETE	102	14322	Aug 25	NEW PATIENT LONG
3	14105	Aug 2	COMPLETE	53	13069	Aug 13	FU GENERAL	103	000000024517	Aug 26	YAG LASER
4	000000033538	Aug 2	COMPLETE	54	13833	Aug 13	NEW PATIENT LONG	104	14457	Aug 26	EMERG VISIT NEW
5	000000033012	Aug 2	COMPLETE	55	14095	Aug 13	NEW PATIENT LONG	105	14324	Aug 26	NEW PATIENT LONG
6	14199	Aug 3	COMPLETE/NEW	56	13906	Aug 16	EMERG VISIT	106	14482	Aug 27	EMERG VISIT NEW

Other Topics

Other topics that are related to revenue cycle management

- Contracting
- Credentialing
- Practice Management/EHR System Selection
- Outsourcing/co-sourcing

Other Topics

Contracting

- To effectively maximize practice revenue, it is essential to know what you're contracted rates are for the different carriers with which the practice is contracted, as well as making sure your Medicare fee schedule is current and tied to the Medicare jurisdiction where the practice is located.
  - Do you know what you're contracted rates are for your most common codes with your biggest payers?
  - Is this being tracked?

Other Topics

Contracting

- Most modern practice management systems will allow you to load contracted amounts into the system. However, we've found this to be more cumbersome than it's worth and doesn't account for variances to the standard fees (i.e. multiple procedures discounts).
- Another option is to build a grid of the carrier allowables that your staff can check, or that you can match against reports you run of what the carriers pay you. On the next slide is an example of a snip from table we built for a client of ours. The table resides on Google, can be easily referenced by the staff, and can be update real time as rates change.

Other Topics

Contracting

	A	B	C	D	E	F	G	H	I
		2021 ALLOWABLES SCHEDULE							
	CODE	PRACTICE FEE	MEDICARE *	PHP MEDICARE	PHP COMM (HMO)	ANTHEM BCBS PPO	NV MCD	UHC COMM	UHC MCR
	99202		$75.24	$75.24	$91.21	$116.98	$73.09		$75.24
	99203		$115.87	$115.87	$140.46	$169.09	$106.04		$115.87
	99204		$173.20	$173.20	$209.97	$256.69	$162.51	$213.82	$173.20
	99205		$228.77	$228.77	$277.33	$323.22	$202.15		$228.77
	92002		$88.23	$88.23	$105.23	$126.96	$73.19		$88.23
	92004		$153.41	$153.41	$182.99	$232.85	$132.74	$192.07	$153.41
	99212		$57.61	$57.61	$69.84	$68.19	$42.99		$57.61
	99213		$93.92	$93.92	$113.85	$114.21	$71.58		$93.92
	99214		$133.25	$133.25	$161.53	$167.98	$105.48		$133.25
	99215		$186.25	$186.25	$225.79	$226.20	$141.04		$186.25
	92012		$91.72	$91.72	$109.40	$133.61	$76.65	$108.08	$91.72
	92014		$129.27	$129.27	$154.19	$193.49	$110.90	$156.83	$129.27

Other Topics

Credentialing

- Making sure all the practice providers and locations are properly credentialed with Medicare and the private insurance carriers is critical for making sure the revenue cycle is managed. One simple mistake can lead to tens of thousands of dollars being irrecoverably lost. Having a provider see patient with whom he or she is not yet credentialed essentially means they are providing free services!
- Credentialing is definitely not something to be done “on the side” or in someone’s spare time. It is painstaking work, and the carriers seemingly make it more difficult every year.
- It’s also important to watch for mistakes the carriers make with credentialing. Fighting them can be a long and difficult proposition, but the alternative is losing money that rightfully should be paid for services rendered.

Other Topics

Credentialing

- At its core, credentialing is a process of managing myriad details and particles such that everything is accounted for, and everything is submitted correctly the first time and on time! It is also a process of knowing when providers need to be “re-credentialed.”
- Anything that drops through the cracks when credentialing will invariably cost the practice revenue.
- Having a system in place to manage all the details and particles clearly and that calls to attention items that need attention is essential to be successful with credentialing.

Other Topics

Practice Management/EHR Software Selection

- Everything related to revenue cycle management goes through the computer system. You want to make sure you choose one that is up to the task being demanded:
  - It is relatively easy and intuitive use.
  - It has robust reporting, ideally with a custom report writer that gives you access to the data fields.
  - The providers are comfortable working with.
  - Has strong support and is updated regularly to reflect the ever-changing landscape.

Other Topics

Practice Management/EHR Software Selection

- When choosing a new system, get clear about what you need and expect your system to provide for you and the practice. Speak to colleagues who are using systems that you are considering. Find out what the shortcomings are. There is no perfect system – they all have their shortcomings!
- Have the vendor give you access to a "sand box" environment where you can play around with the system so you can get a sense of it's look and feel. Given you'll be working on it everyday, it's important that you can live with it!
- Have the providers play around with the EHR. They MUST be comfortable with the software and confident they can fully capture their notes.

Other Topics

Outsourcing/Co-sourcing

Sometimes practices find they need to outsource all or part of the revenue cycle management. The reasons are varied for why this may be a necessity. The following are some of the reasons why a practice might consider outsourcing or co-sourcing:

- Cannot hold on to good people in the billing department.
- There is a big issue or problem that needs immediate attention that the practice does not have the bandwidth for.
- The practice needs the space that had been occupied by the billing department.
- The practice has grown beyond the capacity of the existing billing team.
- Cannot achieve acceptable performance.

Other Topics

Outsourcing/Co-sourcing

If you're considering outsourcing, some critical things to keep in mind:

- Get references. Do not engage anyone without checking at least 2 to 3 existing clients.
- Make sure who you're talking to really knows and understands ophthalmology billing – preferably, one who specializes in ophthalmic billing.
- Have they worked on your computer system? Every system is different, especially on "back end."
- How are clients assigned, and how is the company organized?
- Full transparency if non-negotiable. You must have full admin rights to the system.

Summary

Medical billing involves many particles and many places where things can “fall through the cracks.”

Excellent revenue cycle management requires:

- A well-designed business process for each step in the process.
- Tools and reports to monitor the performance and effectiveness of each step in the process.
- The use of technology tools to support the staff and to increase overall efficiency and effectiveness of the revenue cycle.

Thank You!

We appreciate your participation in the workshop and your commitment to excellent revenue cycle management.

For question or to discuss any section of the workshop, please contact:

Practice Management Resource Group

- Curt Hill – 708.623.8202 – chill@medicalpmrg.com
- Donna Connolly – 708.623.8203 – dconnolly@medicalpmrg.com
- Jana Holt – 708.623.8290 – jholt@medicalpmrg.com