UNDERSTANDING **MEDICAL REVENUE CYCLE MANAGEMENT**

NISOS HEALTH

By Nisos Health

VOLUME I

Understanding medical revenue cycle management

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GUIDE

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Understanding medical revenue cycle management

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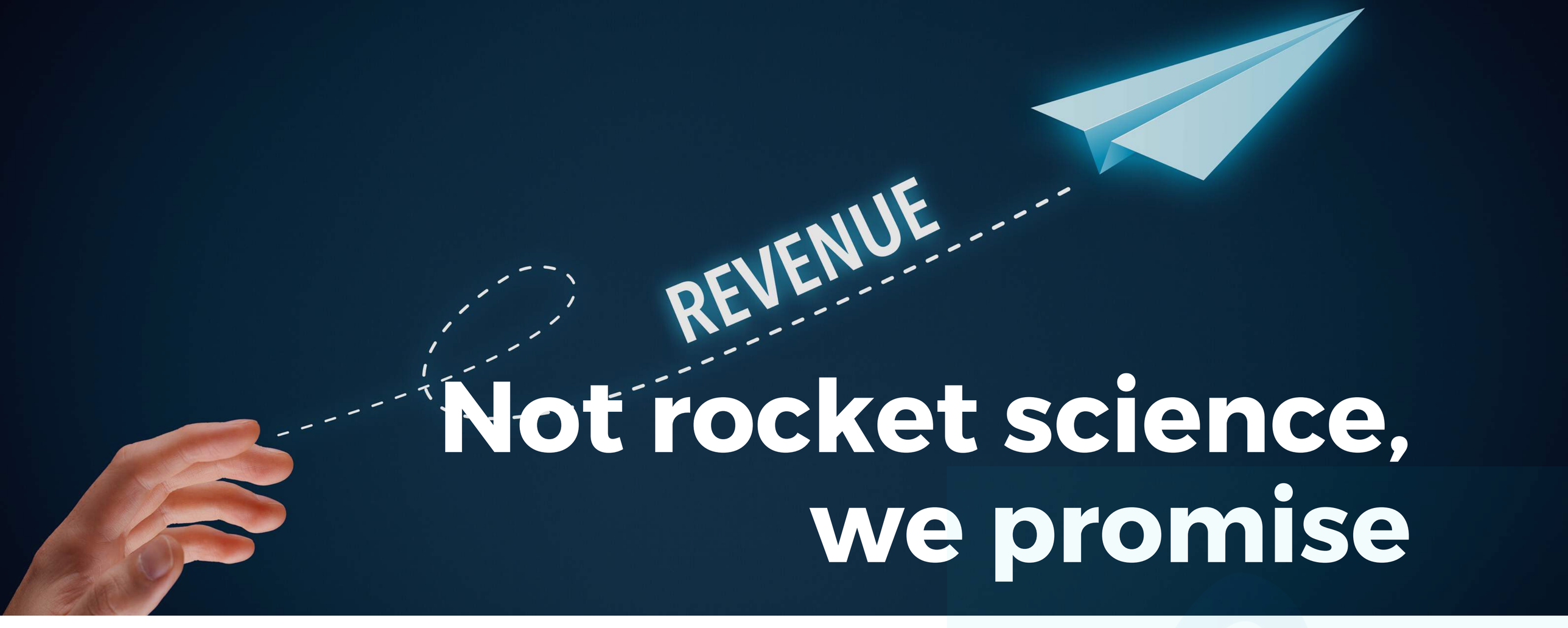
Frequently asked questions answered here to help you understand medical revenue cycle management better.



Not rocket science, we promise

Medical billing and revenue cycle management is not rocket science, although sometimes it certainly seems so. We all usually get caught up in the daily grind of denials.

Taking a step back and wrapping our heads around the “CYCLE” part of the revenue cycle generally helps us understand why things go wrong, end up in denials and why we spend more money in account receivables.. I.e. We spend money in recovering money due. Ugh.

Do not confuse medical billing with medical revenue cycle management. Medical billing is only one part of the entire financial management process for a healthcare organization.

If you want to get paid more and collect each dollar you are owed for the patients you see, you really do need to understand financial management a bit better.

At the end of the day, there’s no magic to this. Think of revenue cycle management along the same lines that you manage your household finances.

Steps in the medical billing revenue cycle

We are not discussing self-pay patients here. Self-pay patients are a lot simpler.

Your patient pays out of pocket – no insurance companies to deal with, no claims to file, no hassles. You set the charges and the patient decides if they want to avail your services at your asking price or not. If they do, you service them, they pay you. Case closed.

We are discussing the insurance claims processes below. They are not complicated either – although sometimes they seem mind-boggling.

Simple to understand. Read below to get a detailed explanation for each step as well.

1. **Credentialing:** You / your doctor gets enrolled with an insurance company / payer. They get credentialed with the payer and are contracted by the payer at predetermined rates for specific services (CPT codes). This contract is specific and it states that for this service, under these conditions, at this location of service, the payer will pay the doctor this $ amount if the doctor submits the claim with specific supporting documentation. You already know this.
2. Once a doctor is “par” (participating) with a payer and accepts certain plans of that payer, the doctor (provider) is considered in-network for that provider. Each patient that has that insurance and that specific plan can now make an appointment with that doctor. You already know this, I am sure. Just a reminder.
3. **Eligibility:** When the patient makes an appointment, you of course make sure that you accept that patient’s insurance and the specific plan they have. After that, you ensure that the patient’s insurance is going to be valid on the date of the appointment.
4. A patient’s eligibility needs to be valid ON the day of service. I.e. On the day the patient is treated. Even if you had checked the patient’s eligibility on the day you gave them an appointment, they might have terminated their insurance (or have their insurance coverage terminated) the day before their appointment. BE CAREFUL and BE WARY of this. ALWAYS, ALWAYS, run an eligibility check of the next day appointments.
5. **Prior Authorization**: Eligibility is the first level of “authorization”. That’s still not a guarantee to pay. You ALWAYS need to know whether the patient’s plan covers the service (CPT) that is going to be performed or not. Over time, of course, you will very easily know which ones are surely covered and which ones are almost always in need of authorization. Prior Authorizations take time to get done. BE CAREFUL and BE WARY of this. ALWAYS be on high alert w.r.t prior authorizations.

6. Collecting patient responsibilities: Based on the contract your provider (doctor) has with the payer AND the contract your patient has with the payer, YOU are required to collect dues from the patient. Yes YOU are responsible. By contract Yes, my friend. So, never feel shy. Collect, each time, every time. Before the patient goes into the office with the technician. We would advise you to collect even when you give them an appointment on the phone (if you use our NisosHealthCRM, you can). This ensures that the patient has no intentions of being a no-show.
7. Coding: Each visit has to be coded. You know this already. Your doctor circles things on a thing called superbill (yes, most doctors still use that). That superbill contains the CPT code. Meanwhile, they enter the ICD in the EMR. You know the difference between CPT code and the ICD already. The CPT is WHAT the doctor did (service) and the ICD is WHY the doctor did what they did. Cool? Coding is the interlinking of CPT to multiple ICDs. You are going to post charges (aka submit claims) to the payer stating that “I did CPT 123 because of ICD 1, 2, 3 on patient A on date xx for charges YY (which is almost always 3x of Medicare set amount each year). So, pay me pretty please”. The payer is going to pay ZZ (contracted, allowed amount, which goes back to the contract defined in the credentialing step). GET THIS CODING PART RIGHT. If you don’t have coding certifications, get certified – it’s not expensive to get certified.
8. Charge posting: Prepare the charge or if your PMS does this for you, check the charge for billing compliance. Prepare the claim and add all necessary information to ensure a clean claim. Then, transmit the claim(s). I would say you double, triple check before transmission because the more you check your work, the less chances of denials and the more you avoid double the work and the more you reduce A/R.
9. Adjudication: Within or after 30 days, monitor payer adjudication for the claim(s) you submitted. The claim is either going to be denied or paid. It will either be paid fully or paid partially and denied partially. When the claim is paid, the payer is going to bundle multiple payments into one. Your team will have to deconstruct this and make sure that payments are posted in your charge posting software against the claims made.
10. Denials: If needed, handle the denial based on why the claim was denied.

What is the revenue cycle for medical billing

The entire revenue cycle at your healthcare business follows a few steps.

A patient books an appointment with you.

You might accept their insurance.

You might not accept their insurance. When you do not accept the patient's insurance, the patient is a self-pay patient.

If you accept the patient's insurance, you may accept the patient's plan.

You may not accept the patient's specific plan. In this case, you would have to charge the patient as "out of network".

Credentialing and provider enrollment

All of this is made quite clear to you and your staff during the credentialing step of revenue cycle management.

Before the patient comes in, your office checks for the insurance eligibility of the patient. Most EMRs give you a simple way to check patient eligibility. This just shows that the patient will have active insurance on the date of their appointment.

Insurance eligibility verification

What could go wrong? The patient might terminate their insurance just before they visit you. Alternatively, the insurance company (payer) might terminate the insurance just before the patient's appointment date.

When that happens, the patient is no longer covered. All of this is made quite clear to you and your staff during the eligibility verification step of revenue cycle management.
The patient arrives at your front desk. At this point, your frontdesk knows the copay amount that the patient has to pay to see you.
If it is a self pay patient, then your office needs to charge the patient the same amount that you charge the insurance company (unless you are using a sliding fee scale).
This copay amount needs to be paid not only because you need to get paid, but also because you signed an agreement with your payer (insurance company) that you will collect that copay from your patient. When you collect that copay from your patient, the payer agrees to pay you a certain contracted (predetermined) amount.
All of this is made quite clear to you and your staff during the credentialing step of revenue cycle management.
Your office knows how much to collect because they have taken care of that during the eligibility verification step.

Prior Authorization / Pre certification

You see the patient and diagnose the patient with certain ICD codes. To diagnose the patient, you followed some procedures. This procedure has a CPT / HCPCS code.
When the patient comes in for the first consult, you are almost 100% sure that the visit (consult) CPT is covered. However, while seeing the patient you might want to perform certain other procedures (each one of those procedures also has a CPT).

You do not always know whether the additional CPT you performed is covered by the patient's insurance.
You may choose to perform those procedures right away.
You can also ask the patient to come back for the additional procedure at a later date.
Either way, before you perform that procedure you want to know whether the insurance company / payer will cover that CPT or not.
The insurance company / payer might require you to get a prior authorization for the CPT that you are proposing.

So, your office might need to submit a prior authorization request to the patient's payer. The payer might deny your request or might approve your request. When the payer denies it, they will submit the denial reason back to you. You can choose to appeal that decision and would have to provide your reason / proof of medical necessity.
All of this is made quite clear to you and your staff during the prior authorization step of revenue cycle management.

Charge posting

After you have seen the patient, you or your staff will need to submit a claim to the insurance payer. To be able to submit the claim, your staff is going to need the CPT and the ICD codes.
Effectively, you or your billing staff is going to say that you, the doctor, performed CPT 1234 because they diagnosed the patient with ICD A123.

What is the difference between a CPT code and a diagnosis code?

CPT is just a numerical representation that describes what was done to the patient during the consultation/visit. This will include diagnostic, laboratory, radiology, and surgical procedures.
The ICD code on the other hand, is an alphanumeric representation of why what was done to the patient was done. This identifies a diagnosis (or diagnoses). ICD describes a disease or medical condition.

What is a DRG code?

DRG means "Diagnosis-related group". This is typically used in hospital cases and is a system which classifies hospital cases. This classification is done according to certain groups, which are expected to have similar hospital resource usage (i.e. cost).

Further on charge posting

For each CPT code, there's a specific contracted amount that the payer is going to pay you (no matter what you charge the payer).
Keep in mind that diagnosis code is also known as DX code in medical billing.
The CPT code is also called as PX code in medical billing
Your biller might need to know the modifiers as well. Modifiers are used with the CPTs when they need to differentiate the medical services rendered to the patient (there is specific guidance around that).

Your biller will need the accurate Date of Service.
You will also need to provide the units of service to your biller. This will indicate the quantity of procedures to claim for.
If, for some reason, a prior authorization was needed to post this charge, the biller is also going to need an authorization number (pre-certification number).
Then, your biller is going to enter the “Billed amount”. This is also called “charge amount”.
Much of this information should or could be available in your “SuperBill”. That is, if you are still using superbills. Paper superbills are typically easier and faster to use than entering that same information in your EMR. As you know, it’s just a form listing procedures, service and diagnosis codes for a patient’s visit.
After all this data is gathered and entered into the charge posting software, your medical biller will submit this to the insurance company / payer.
Hopefully your office is already using electronic submissions. If not, this charge will be posted via a paper claim (discussed below).
When you submit the charge electronically, it goes through a clearinghouse (e.g. EMDEON) and is submitted to the payer (since they both speak the same language).
The above steps of revenue cycle management is collectively called charge posting.

How does coding affect the revenue cycle?

Medical Coding is crucial in revenue cycle management (as you might have already guessed).
If you have inefficient practice workflows, you could be slowing down your medical billing department even further.
Coding correctly AND on time can make or break your medical billing process. This will, of course, affect your collection rate and days in AR as well.
When you or your biller has a backlog of charts to code, you are effectively running the risk of missing the timely filing deadlines set by payers. Each payer has their own timely filing limit set up and your medical billing department needs to be cognizant of those timelines.

What is the difference between professional and institutional claims?

Pretty simple and you might have guessed this just as well. Institutional claims are submitted by hospitals and skilled nursing facilities (SNFs). Professional claims are submitted by physicians, suppliers and other non-institutional providers.

What are the two types of forms used for health services billing?

This really depends on whether it's an institutional claim or a professional claim.

Professional billing is going to use the CMS-1500 form and/or the 837-P form. The CMS-1500 is the paper version (the red ink one). The 837-P is the electronic version of this same claim form.

Meanwhile, institutional claims use the UB-04 form and/or the 837-I forms. The UB-04 form, (or CMS-1450) is the paper version and the 837-I is the electronic version. That's it.

Do note that institutional billing is a lot more complex (and the forms as well) than the professional one.

What are the codes for medical billing?

Overall, you have 3 categories of code in medical billing

- Category I Codes – These are the 5 digit CPT codes
- Category II Codes – These are performance measurement tracking codes. They are alphanumeric and will have a letter as the last digit.
- Category III Codes – These will also have a letter in the last digit. These are temporary data collection codes that CMS uses.

The ones you are going to deal with on a regular basis are broken down here.

- (E&M) Evaluation and Management: 99201 – 99499.
- Anesthesia: 00100 – 01999. You also have 99100 – 99140 (most of you will not handle these)
- Surgery: 10021 – 69990.
- Radiology: 70010 – 79999.
- Pathology and Laboratory: 80047 – 89398.
- Medicine: 90281 – 99199. You also have 99500 – 99607

Rejected claims

Do not confuse this with a denied claim.
An electronic claim is submitted (usually) to a clearinghouse (e.g EMDEON). If there are errors in the claim itself, the claim is rejected by the clearinghouse (trust me, it's better than a denial).
It's better this way because the payer would have denied your claim and that would have contributed to longer account receivable days anyway (and more work).
Your claim may get rejected by the clearinghouse for various reasons.
It could be a simple clerical error.
It could be a mismatch between the procedure code (CPT) and diagnosis (ICD) codes.
These rejected claims will be sent back to your practice and your biller will have a chance to correct and resubmit the claim.
Think of this process as "claim scrubbing" (which it actually is).

What are the reasons for claim rejections?

There could be several reasons. E.g.

- Incorrect patient demographics – including patient gender, name (spelling or missing out middle name), date of birth, member ID, etc.
- Provider information issues – yes, it does happen Your team might have screwed up the rendering provider information as well (NPI, name, contact info etc)
- Incorrect payer information – e.g. wrong member ID, address.
- Incorrect ICD/CPT/HCPCS codes. Yes, codes are confusing and codes are changed each year (call them enhancements). Sometimes modifiers used do not belong to the CPT being submitted. Your claim might get rejected due to these errors as well.
- Mismatched or missing codes – We have seen CPT and ICDs being reversed. This kicks the claim back immediately
- Duplicate claims – this is a bit harder to catch and it usually eats up a lot of biller time. A biller might not have noticed that a claim for a particular patient, particular date of service and CPT has already been submitted. Such claims would have been rejected by the payer anyway. This is a huge headache.

Payment posting

Now that the charge has been posted, you will need to wait for the outcome.
The payer can pay the claim in full if everything went correctly.
The payer can pay in part and deny some parts of your claim.
The payer can deny the claim altogether.
There's another state that the claim might be in. That's called "no response". This is where the payor has not yet made a determination on your claim. Typically, payers ask for a minimum of 30 days before responding to your claim. During this time, the claim stays in a "no response" state.
Every day or on certain days a week, you will notice payments from your payers. Of course, the actual payment will go to your bank directly or will be sent to you via check which you will deposit in your bank. Meanwhile, the payment advice will come to your charge posting software or along with the check that you received. This is known as the ERA (electronic remittance advice) or a RA (remittance advice) when it comes to you via the mail.
Keep in mind that you might get multiple checks or a single check with multiple remittances for multiple claims.
Also, understand that it's better to use electronic remittances as ERAs follow a universal format (ANSI) called 835. If your software (most charge posting software can) can handle ERA files, you are good to go.
Along with the ERA you are also going to get an explanation of the benefits (EOB) file – either electronically or via mail.
This EOB is going to explain the claim payment. This will tell you about any or all patient responsibilities as well. E.g. co-insurance, deductible, copay.
The EOB will state the "Billed Amount" – the amount you or your office billed the payer. It will contain the "Allowed Amount" – the amount that you and your payer had contracted for, while credentialing. The EOB will contain the "Not Covered" section that will tell you the amount not covered by the patient's policy (depends from employer to employer). It will also tell you the "Deductible Amount" – if the patient's plan has a deductible amount, this amount will be specified in the EOB.The patient is supposed to pay this amount.
The EOB will tell you "Provider Paid" – that will be the amount that the insurance company actually paid you.

It will also tell you the “Adjustment Amount” – this is the amount by which the payer’s payment is reduced due to “adjustments”. The reason for the adjustment will be explained by the Claim Adjustment Reason Code (CARC).

Finally, the EOB will tell you the “Patient Responsibility” – that’s the amount that the patient still has to pay you, the provider.

With the above information, you or your medical billing staff can apply the insurance payment(s) to reconcile the same.

For this, the lump payment would need to be broken down and applied against each individual claim.

This whole step is known as payment posting in revenue cycle management.

You can start submitting secondary claims once the primary insurance payments are posted. That, of course, would be “charge posting” as explained above and even that will follow the same payment posting steps mentioned above.

Finally, once all insurance payments have been received and account adjustments made, the remaining patient responsibility can then be billed.

Sample ERA / EOBs

Take a look at the images below for remittance advice and EOBs to understand EOB and ERAs better.

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association.

Explanation of Benefits

December 01, 2011 — *This is not a bill.*

Subscriber information

First: John A
Last: Doe
ID: W1234567891
Blue Options Plan

Need more information?

Find answers online at **mybcbsnc.com**

Customer Service (Monday-Friday, 8 a.m. - 9 p.m. EST) 1-888-234-2416
Servicio al Cliente (Lunes – Viernes, 8 a.m. - 9 p.m. EST) 1-888-234-2416

Additional Information

Please save this form for your tax records. Your balance may not reflect any prior payments made by you or another insurance company.

The information listed in the “Benefit Year Summary” section indicates the most current benefit period information on your plan as of the date of this notice. The “Amount Satisfied” will reflect the total amount applied throughout your plan’s benefit period, which may include amounts applied before and after any changes in benefits or dependents covered throughout the current benefit period.

Para obtener asistencia en español, comuníquese con el departamento de servicio al cliente al número que aparece al respaldo de su tarjeta del seguro.

Benefit Year Summary - For benefit period starting 01/01/2011

Blue Options Plan	In-Network Deductible		Out-of-Network Deductible		In-Network Out-of-Pocket		Out-of-Network Out-of-Pocket	
	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied	Plan's Maximum	Amount Satisfied
John A	$700.00	MET	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Jane B	$700.00	$0.00	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Joe C	$700.00	$0.00	$1,400.00	$0.00	$3,210.00	$0.00	$6,420.00	$0.00
Family	$2,100.00	$700.00	$4,200.00	$0.00	$9,630.00	$0.00	$19,260.00	$0.00

These benefits require you and/or your family to reach payment maximums, labeled "Plan's Maximum," before your plan pays a greater share of the cost. These maximums can be reached in two ways: when you've satisfied your individual maximums, or when your family has met its maximums. Payments made by members are credited both to their individual Amount Satisfied and to the family's, up to the individual maximum amount. Individual maximum requirements are waived when your family maximum is reached. The amount satisfied column will read "Met" if an individual or family maximum is satisfied.

Patient: John A. Doe #: W1234567891

Medical Services Detail Claim #: 01-102510-046-40	Your Provider Billed	Member Benefit: Allowed Amount	Member Benefit: Member Savings	Member Benefit: Your Plan Paid	Amount Your Provider May Bill You: Copayment	Deductible	Coinsurance	Other Liability	TOTAL	Reason Code (See below)
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$875.00	$600.00	$275.00	$0.00	$0.00	$600.00	$0.00	$0.00	$600.00	
	Service: MEDICAL CARE									
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$150.00	$100.00	$50.00	$0.00	$0.00	$100.00	$0.00	$0.00	$100.00	
	Service: LABORATORY									
Provider: JOHN SMITH **Date(s):** 11/21/2011-11/21/2011	$50.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00	$50.00	ENB
	Service: SUPPLIES									
Total for Claim # 01-102510-046-40	**$1,075.00**	**$700.00**	**$325.00**	**$0.00**	**$0.00**	**$700.00**	**$0.00**	**$50.00**	**$750.00**	

What our codes mean

ENB Claim denied. Service is not covered for either the primary diagnosis or service code listed. May resubmit if other covered diagnosis or service codes apply. Claim will be reopened upon receipt of requested information within one year of denial.

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Claims denials – What are the types of denials?

Your claim could also get denied – either partially or completely.
There are two types of denials: hard and soft.
Hard denials – there's not much you or your billing team can do about it. You will have to write this off, accept the lost revenue and make sure that you and your medical billing team doesn't make this mistake again.
Soft denials on the other hand are considered temporary. Your medical billing or revenue cycle management team has the potential to get this reversed.
Your team should work with you, the provider, to correct the claim.
This might require you to provide additional information / visit note /document to support medical necessity.

Why are medical claims denied?

Denials will happen – we can guarantee it. It happens to every single provider, practice, health system – no matter how good/bad their medical billing team is.

Some of the reasons for claim denial include (but are not limited to):

- Credentialing Issues – The provider is not at par with the payer.. I.e. the credentialing department never got this provider empanelled but submitted the claim with this provider as the rendering provider.
- Eligibility issues – The patient is not enrolled in the plan or with the payer in the claim. This can also happen when the patient was out of coverage (either payer or patient might have terminated coverage) on the date of service.
- Prior authorization issues – As mentioned above, you performed a procedure and your biller submitted the claim with a specific CPT. However, that specific procedure / CPT is not covered by the plan that the patient is participating in. This means that you were required to get precertification / prior authorization for this procedure. However, the prior authorization is not on file. Sometimes it so happens that you did receive the prior authorization but your medical biller forgot to include the authorization number in the submitted claim.
- Inadequate documentation. These days payers are asking for more and more documentation (consult notes) for claims submitted. Your claim could get rejected due to the lack of adequate supporting information/documentation. You need to have enough documentation via visit/consult notes to support the reason for performing the medical procedure your claim uses.
- Your claim could also be missing a valid referral number. At times (especially with HMOs), you need to have a referral from primary care before your payer will pay you for the patient visit.
- Your billing department entered incorrect demographics information in the claim. The procedure you performed might be age-inappropriate according to the demographic information on the claim. Your billing department might have just screwed up and not submitted the correct demographics of the patient.
- Undercoding claims. This typically doesn't always belong in your medical biller's hands. However, you need to know about these. You might have (intentionally) left out a CPT from the superbill. Sometimes providers do so to avoid audits and you might have done the same as well. You might have coded for a less serious procedure. You could have undercoded for various reasons. However, this is illegal/fraudulent.

- Upcoding – pretty much the opposite of undercoding. This is where the provider or the practice or the biller adds CPTs in the claim that does not belong there. In other words, the patient was never treated for that procedure. There are several practices (although fraudulent and illegal) that do this – to collect more from the payer.
- Clinical documentation issues. Again, this is out of the biller's hands. You, the provider, are supposed to provide adequate documentation for each patient visit/consult. That not only bolsters your claim submission but is also necessary for appropriate patient care continuity. The sad part is that when your claim gets denied, you are asked for supporting documentation. If your documentation is sloppy, the chances of getting paid are quite slim.
- Payer issues. This is also out of your billing department's hands. Sometimes a claim is denied without enough explanation (codes) in the EOB document.

How to reduce medical claim denials?

The more proactive you are in your billing department, the better you will be at reducing claim denials. If you understand the reasons claims are denied (read above), you will be in a better position to reduce those denials.

- Continuing education. There are no two ways around this. Codes change and will change (sometimes yearly). New codes are introduced and older codes are phased out. Codes are moving toward more specificity. That means, they are getting more granular. You need to invest in yourself, your career as a medical biller.
- Double check you work. We cannot say this enough. Even if this means that you need an extra day to submit claims – do so. We have seen so many simple clerical errors (mostly data entry errors) that derail a claim. Double check your claim before you submit it.

- Communicate and collaborate. You are not clinically trained. Revenue cycle management takes a large team with several moving parts and several people involved in the process. Make sure you are talking to others on your team. Questions about the visit notes? Don't be afraid to ask your providers for further information. Don't be afraid to kick back a visit note or superbill to the providers either.
- Stay in touch with the payer reps. When you submit the claim, it stays in the no-response bucket. Be in touch with the payer reps so you can be aware of errors they have already identified (if any). Start working on those and proactively so that you can re-submit as soon as your claim has been submitted.

Appealing medical claim denials

One point to note here. If your billing team strongly believes that you should not have been denied a particular claim (or claims), you can always appeal the denial.

Do keep in mind that Medicare/Medicaid are a bit harder and arduous to deal with (they take longer). We find that many practices don't bother with them. In our opinion, you still should try to appeal the denial. We can show you how to.

Calling the payer

If you do not understand the claim denial code in the EOB/ERA, call the insurance company.

When you call your payer line, make sure that you record the date/time of call, the customer service rep you spoke to and the reference number of the conversation (ticket). Put that information on file (usually, we put it as a note on the pt record itself).

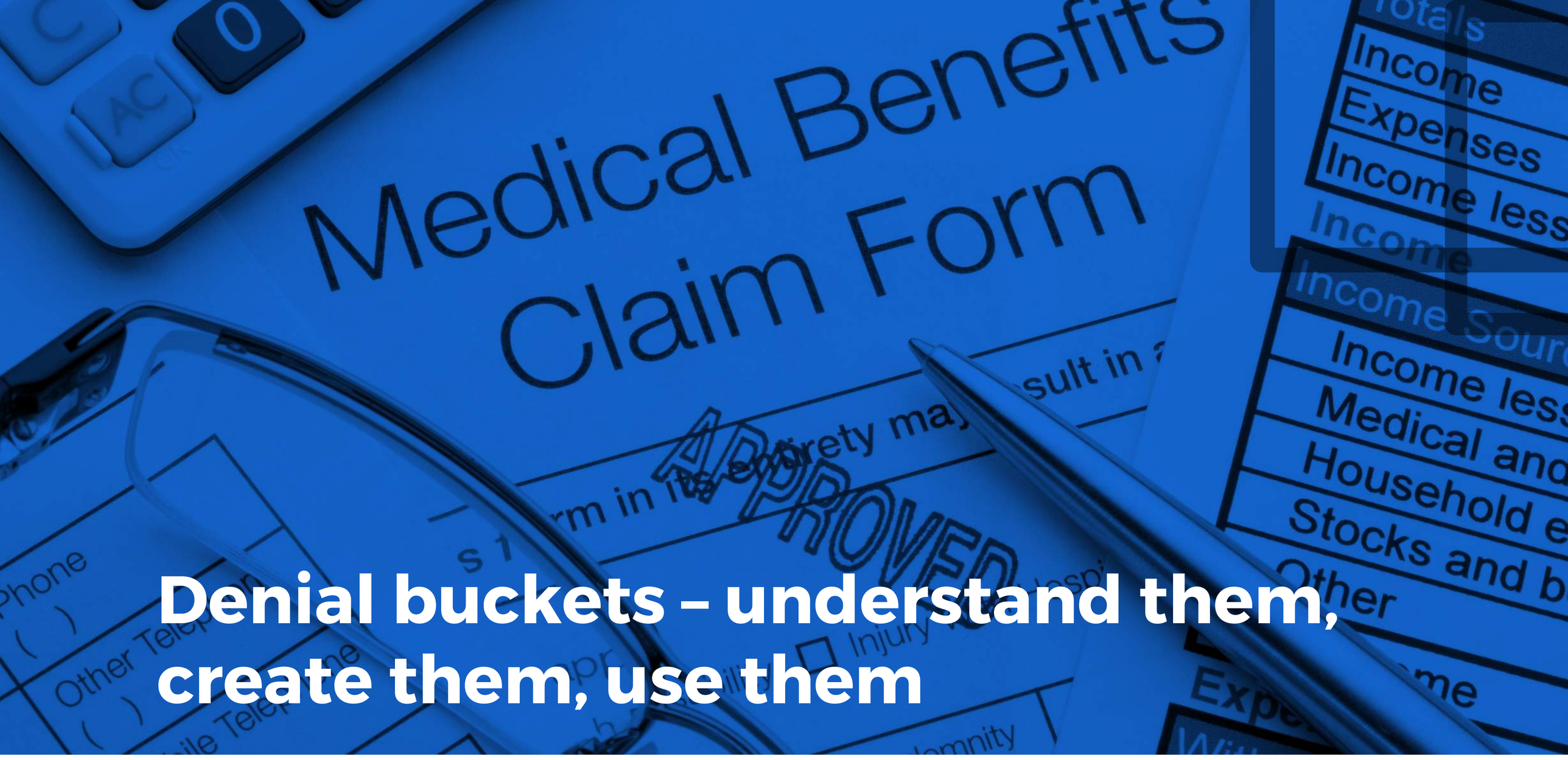
You are going to have to call the payer rep again and having the reference number speeds up the process. When you do understand the issue and are re-submitting the claim to get paid, make sure you are also using the reference number there. This allows the claim to be processed as a corrected claim and not as a duplicate claim.

Prioritize your denials

You are not going to have enough time to appeal every denial.

Handling denials is a labor-intensive process and labor = costs. Make sure that you prioritize which denials you are going to work on first.

Typically, our advice is to go after the high dollar value denials first. Clear those out, then go to the next bucket of denials.



Denial buckets – understand them, create them, use them

Understand the denials – very, very well. A few common denial reason codes (that you get in an ERA) are:

- Provider is considered out of network.
- No prior authorization or precertification.
- Incomplete claim information entered.
- Medical necessity – not sufficiently supported documentation provided.
- Lower level CPT was deemed appropriate but your provider did a higher level, more costly service.
- Procedure or CPT is not covered in a patient's benefits.
- Ineligible patient – i.e. patient no longer covered
- Pre-existing conditions – not covered by the policy.
- CPT and ICD mapping/linking issue.
- Bundled service was unbundled – i.e. you submitted multiple codes for a set that is included in a bundled service

Some of these denials are preventable and some are not preventable.

Your practice management system will show you a report on what is preventable and what is not.

Note these. Preventable denials should be brought down to zero. They are simpler to fix and you just needed to be more diligent about your billing process and integrity checking.

Each payer has specific requirements as well. Make sure you are aware of those.

Research has shown that it is always more efficient and productive to have individual team members specialize on specific payers. This way, they learn the ins and outs of those payers, thereby reducing the denials.

A generic approach does not work.

Sending appeals letter(s) to the payer(s)

Sometimes you really do not have any other way than sending an appeals letter.
Most payers (if not all) have standard appeal letters on their websites. Yes, you might have to hunt them down, but we recommend that you use those denials letters.
When you send the standard appeals letter, make sure that you include ALL the required information (e.g. member name, ID, date of service, claim number etc).
Denials related to medical necessity are a bit tougher to handle. For this, you need to create a customized letter, have the necessary medical documentation attached to the letter as well.
Do not rely on the knowledge of the payer's claims department.
You obviously have proof or a strong reason to believe why your claim should be paid.
Note down the CPT or CMS or even payer guidelines that you have researched – include those information in your appeals letter.
Include just enough information needed to process your appeal. Never assume that it is better to overwhelm the processor with more information. This will most certainly slow down the appeals process/timeline.
If you are not confident about your ability (or want to save time), just go ahead and recruit a professional reviewer. You can also find (inhouse or external) physicians with experience in billing, coding, HIM or utilization review.

Claim denials workflow

Most practices we work with do not have a workflow / process around revenue cycle management.
Do not make that mistake. If you need to, contact us for a Revenue Cycle Analytics and Revenue Cycle workflow product (it's free to use).

Payer contact list

You always, always need to maintain a list of appropriate contact personnel for EACH payer.
Make sure you and your team maintain a list of denials coordinators (not the accounts receivables) at each payer.
Establish a relationship with them. Make sure they also understand that you and your practice know what you are doing.

Denials workflow spreadsheet or use software

Unless you work for a small practice that barely has 100 claims per month to work on, you cannot possibly manage denials in your head or on paper.
At the very minimum, use a spreadsheet to manage your denials.
Spreadsheets have their own limitations but they are better than managing your denials workflow on paper.
There are several (paid) denial management software in the market. Use them. If you want to use our free denial management software, contact us.
You need to track information about each and every appeal – date appeal submitted, payer, filing requirements.
Set up reminders to follow up – ideally per month. Do not let any appeals fall through the cracks.

Here are the steps of appealing claims

1. Call payer to find out more information about the denial
2. Request a review of the claim on the phone. If they deny this request, you can call the dept of insurance or the Ombudsman office. If nothing works, consider legal action (and let the coordinator know as well)
3. Once you learn more, resubmit the claim. Make sure that you prevent this from being considered a duplicate claim (as mentioned above). You need to file the resubmission with an updated clam copy + the original claim copy. You need to submit the remittance advice (RA) and any further documentation your payer rep has asked for. Make sure you mark it as “RESUBMISSION”. This will avoid the claim being rejected as a duplicate claim.

What's an average denials rate?

According to MGMA, the average denial rate for most practices ranges from 5% to 10%.

Imagine – even if you are a small practice of two providers, you probably see 50 patients per day. That's about 1000 claims per month.

If you have a denial rate of even 8%, you are looking at 80 denials per month.

Even at a charge of $100 per claim you are (potentially) losing $8,000 a month in denied charges.

On top of this, reworking claims typically costs $25/claim reworked. So, you are spending an average of $2,000/month to rework denied claims. You will never really recover all of the $8,000. Let's say that you are recovering $7,000/- out of those $8,000 denied charges.

At the end of the month, you have lost $3,000 and have only recovered $7,000.

In other words, you need a strong strategy to reduce denials as months progress.

Otherwise you will always be playing catch-up and will always be "busy" but not making enough.

Strategy needed to reduce claim denials

If you have created a workflow and are using buckets to do root cause analysis of denials, you will also very easily understand how to reduce denials.

Denials due to eligibility

This immediately tells you that you need to have better training at the front desk. Maybe the front desk does not have a good grasp of how important their job is. It also tells you that you need to train your front desk and scheduling team to do a better job at rescheduling appointments that failed eligibility checks.

You would even have cases where the provider is considered out of network (based on the work that your credentialing team has done). When that's the case, you can change the provider for that appointment to one that is considered in-network for this particular patient's plan. Or, you can communicate the issue with the patient.

When you find out that there are eligibility related issues, put these patient appointments in an "appointments at risk" bucket.

Your frontdesk or scheduling team should call these patients before the appointment and apprise the patient of their options. The patient can either cancel the appointment, reschedule the appointment until the insurance issues are resolved or they can choose to pay from their own pockets.

The workflow you are using here (or modifying) is that the billing department analyzes the denials, forms buckets, then trains / informs the front desk to make corrections upstream. This strategy allows you to reduce such denials moving forward.

Denials due to coverage issues

For recalled patients, you already know the procedure that your provider wants to perform (vs a new patient appointment). This is clearly mentioned in the visit note and when your front desk made the appointment, they chose this visit type as well.

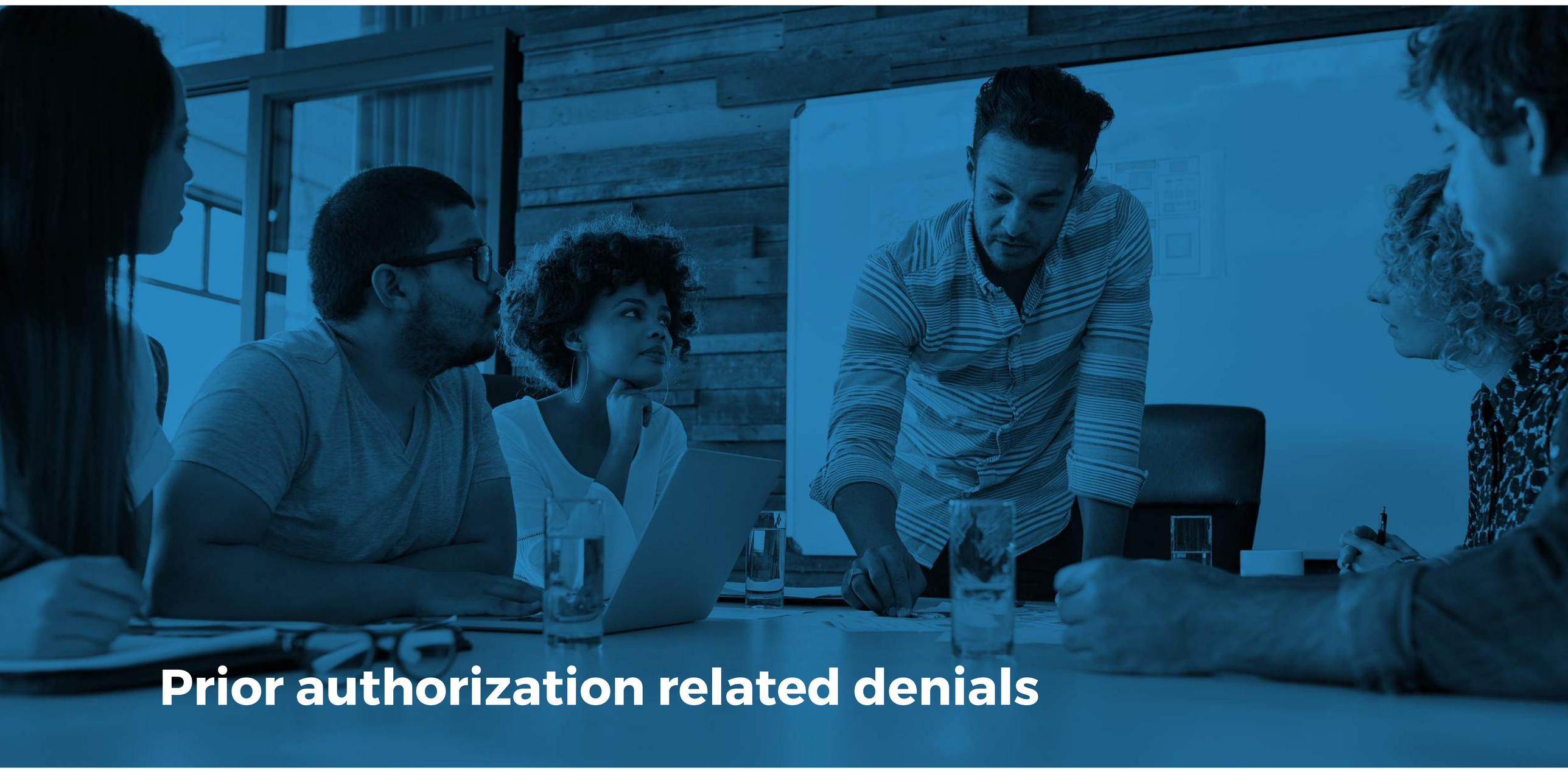
This tells your eligibility team that they need to ensure that not only is the patient covered on the date of service, but that the procedure/ service requested by the provider is also covered by the patient's plan.

In other words, simply having coverage on the date of service is not enough. Your eligibility team needs to find out whether the service is covered by the patient's benefits as well.

When you find out that there are coverage related issues, you need to do the same as above – put them in an "appointments at risk" bucket.

Your frontdesk or scheduling team should call these patients before the appointment and apprise the patient of their options. The patient can either cancel the appointment, reschedule the appointment until the insurance issues are resolved or they can choose to pay from their own pockets.

The workflow you are using here (or modifying) is that the billing department analyzes the denials, forms buckets, then trains / informs the front desk to make corrections upstream. This strategy allows you to reduce such denials moving forward.



Prior authorization related denials

When your eligibility team is checking for a patient's eligibility for the specific procedure proposed by the provider, they will also find out whether this service/procedure requires prior authorization or not.

Give yourself adequate time to get the prior authorizations done. Prior authorization does take time and the payers do not always respond on your schedule. If you find out that a procedure requires prior authorization by the patient's plan, immediately move the appointment to a "appointments at risk" bucket.

As described above, you need to call those patients and give them the options discussed above. In all probability you are going to get the prior authorization if you do your job properly so the patient would just need to reschedule their appointment to after you obtain the prior authorization / precertification.

The workflow you are using here (or modifying) is that the billing department analyzes the denials, forms buckets, then trains / informs the front desk to make corrections upstream. This strategy allows you to reduce such denials moving forward.

Denials due to medical necessity documentation

Monitor these closely. Usually you get denials for “Medical necessity” due to mismatched or missing diagnosis. Your payor might consider a particular CPT as a medically necessary diagnosis for another related CPT.

There is no universal rule per se (unless you are dealing with Medicare/Medicaid that has NCDs).

You need to understand AND have a “ready to go” checklist per payer.

This checklist should have this intelligence to show you the medically necessary (deemed) CPT for the related CPT that you are submitting in the claim. You might even need to consult with your provider to get further information on this as well (since clinicals are out of your area of expertise).

Review the documentation, make sure that the documentation supports the diagnosis, then resubmit the claim.

Most importantly, keep building this internal database of yours.

The workflow you are using here (or modifying) is that the billing department analyzes the denials, forms buckets, then trains / informs the coders to make corrections upstream. This strategy allows you to reduce such denials moving forward.

Denials due to bundling

You will have situations where you need to be careful with modifiers.

There are services (per payer) that are considered integral to another service that’s reimbursed. This is called bundling. Most payers will have some technology-based logic that disallows separate payments for each line item. These CPTs will be reimbursed as a bundle.

Make sure you are up to speed on all the bundled services and reimbursement policies. Use NCCI for guidance on the same.

You need to be careful of what you report “together” on the same date. You cannot also unbundle and submit the claim with multiple provider names from the same practice.

Make sure you review the documentation properly. You will see the denied claim line item that’s related to the bundled service/line item. You cannot just blindly resubmit the claim with a modifier. You need to have supporting documentation to be able to appeal that claim or resubmit that claim.

You need to understand AND have a “ready to go” checklist per payer.

This checklist should have this intelligence to show you whether a

CPT is bundled in payments by that payer. Most importantly, keep building this internal database of yours.
The workflow you are using here (or modifying) is that the billing department analyzes the denials, forms buckets, then trains / informs the coders to make corrections upstream. This strategy allows you to reduce such denials moving forward.

Denials due to Incorrect data entry

These data entry issues could be related to demographic information, procedural or diagnosis codes. Usually, the practice management system will do part of the work but it is NEVER 100% correct and your charge posting team and the medical coding team will have to provide their inputs as well.
The workflow you are using here (or modifying) is that the billing department analyzes the denials, forms buckets, then trains / informs the coders and billers to make corrections upstream. This strategy allows you to reduce such denials moving forward.

Denials due to coordination of benefits

Coordination of benefits is an arduous process. It also needs your scheduling team/front desk and your billers to coordinate / collaborate a LOT more than usually occurs in practices.
Several denials are due to the coordination of benefits.
Coordination of benefits usually comes into the picture when your patient is covered by multiple insurances / health plans. By law (COB provision and regulations), all health plans are supposed to coordinate amongst themselves to reduce any chances of duplicate payments for the same procedure(s). It is also built-in this way to maximize the benefits and coverage that a patient obtains.
According to regulations, the primary payer is supposed to pay first. The secondary payor is supposed to pay next.
The tertiary payor is supposed to pick up the rest.
It is YOUR job to know all the insurances that the patient is covered by. This is a crucial task for the scheduling team or your front desk. Each patient registration needs to have ALL the insurances that a patient has.

Get the insurance details at each visit

Our recommendation (based on research and our own experience) is that your scheduling team needs to get in touch with the patient a few days before the appointment to ensure that they truly do know the insurance details of the patient.

Keep in mind that patients flow in and out of insurances many times and the primary/secondary/tertiary coverages will change over time.

This also means that you need to have a concerted effort to keep your patient coverage information up to date as much as possible.

It does not hurt to ask the patient one more time when they are checking in for their appointment at your front desk. Ask the patient about their spouse and dependents as well.

Ensure that you have a policy about this,

Make sure you submit the primary payer's EOB each time

Each payer has their own rules. But every payer does require you to submit the EOB of the primary payer along with the claim you submit to them.

Make sure that you have a checklist created per payer and share it with your billing team.

When your medical billing team is doing their due diligence before submitting the claim, it has to pass this "checklist".

Make sure you understand primary and secondary payer determination

Sometimes you can get this info when your eligibility verification team is doing their job. Sometimes you do not.

As a general rule of thumb, if the patient themselves is a subscriber, then the payer of that patent is going to be the primary payer.

Know about the birthday rule – this comes into the picture if the patient is a dependent. When a dependent child is covered by both parents' benefit plan, then you need to find the parent whose birthday (date) falls first in the year. The person whose birthday falls first in a calendar year is considered as the primary. The payer of that parent will be considered as the primary payer.

What percentage of denials are traced back to the front end?

As you can see quite a few of your denials can be traced back to the front end.

In other words, if you fix these errors upstream, you reduce the chances of denials.

As per a Change Healthcare report, frontend revenue cycle teams contribute to 23.9 percent of claim denials.

What is the front-end revenue cycle?

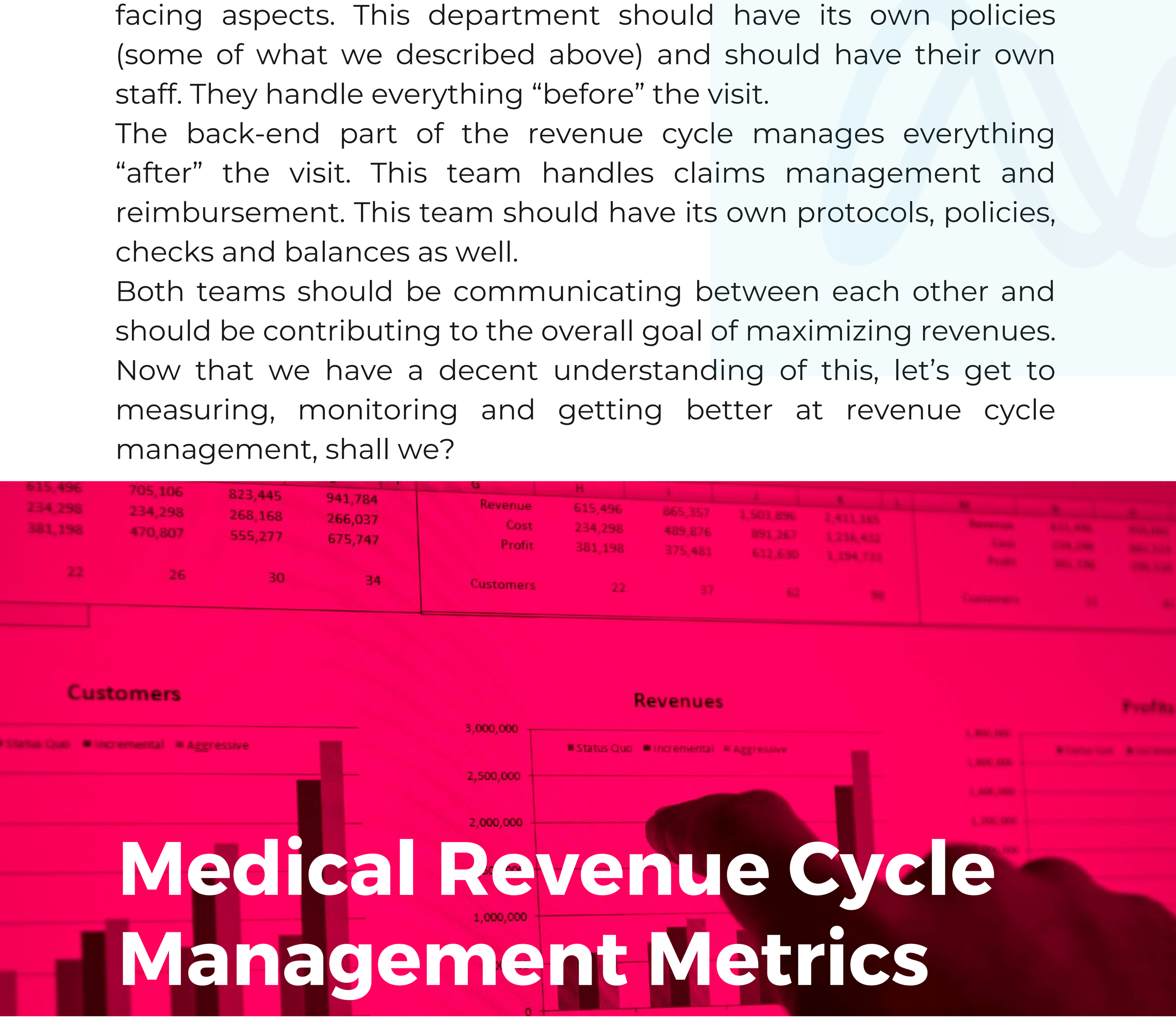
Now that you see the contribution of front end revenue cycle teams (or the lack thereof), it would be good to understand that the revenue cycle teams are (and should be) broken into two sections.

The front-end part of the revenue cycle manages the patient-facing aspects. This department should have its own policies (some of what we described above) and should have their own staff. They handle everything “before” the visit.

The back-end part of the revenue cycle manages everything “after” the visit. This team handles claims management and reimbursement. This team should have its own protocols, policies, checks and balances as well.

Both teams should be communicating between each other and should be contributing to the overall goal of maximizing revenues.

Now that we have a decent understanding of this, let’s get to measuring, monitoring and getting better at revenue cycle management, shall we?



Medical Revenue Cycle Management Metrics

Medical Revenue Cycle Management Metrics guide for 2021. Read this guide if you have transitioned your thoughts from “medical billing” to revenue cycle management. To maximize your practice’s revenues, you need to start thinking of medical billing as a team effort. Read this guide for understanding revenue cycle management processes first (if needed).

Why is revenue cycle management important in healthcare?

As you can understand from the previous guide to understanding medical revenue cycle management, the revenue cycle is truly a “cycle”. Each step feeds the other and the success, efficiency of each step depends on other steps of the revenue cycle.

There is no one that does this perfectly. MGMA typically has KPIs and guidance around RCM performance. We use the same with our clients.

You can also follow the same guidelines as MGMA and HFMA suggests. MGMA actually announces “MGMA better performers” each year as well.

If you incorporate revenue cycle management processes as part of your overall business strategy, this is almost guaranteed to improve reimbursements, accurate billing, compliance and more often than not, greater clinical outcomes.

What is KPI in medical billing?

KPIs are Key Performance Indicators (KPIs). That’s about it – buzzwords.

KPIs help you, the physician leader or you, the practice management staff understand your revenue cycle’s strengths and weaknesses.

As you are well aware of, unless you measure something, you cannot improve that “thing”.

KPIs in medical billing help you measure and help guide your future decisions.

Once you have medical billing or revenue cycle KPIs in place, you will be able to prioritize your staff, your resources and understand / identify the drivers for success and higher reimbursements.

How can hospitals increase their revenue cycle?

First and foremost – understand that revenue cycle management needs a front end AND a back end team. Have KPIs for both front-end revenue cycle management and also for the backend revenue cycle management team.

Employ software or technology to get a better (and easier) grasp of your performance data. Do not get into a situation where you cannot have the necessary decisions at the touch of a button.

We have seen that when we ask most healthcare businesses for performance data, they scramble to print out reports from their practice management system and then divert their already busy staff to do analysis. Not only are their staff not qualified to do analysis, but this also usually affects other business processes that soon become overdue. Do not let this happen. Use technology to your advantage. Do not be scared of technology or data.

There's always going to be payer and patient financial responsibilities. Make sure that your front end revenue cycle management team collects patient financial responsibility upfront.

Try to automate prior authorizations and eligibility as much as possible. Not all of it is really possible and it depends from payer to payer, but even if you automate 30% of all your prior authorizations and eligibility checks, that's better than zero.

As a side note – do NOT depend on the eligibility checks that most EPMs provide you. Dig a little bit deeper. We have found that many a time, a patient might be eligible, but their benefit does not pay for the CPT proposed by the provider.

Have a dedicated revenue cycle manager and a revenue cycle analyst on your team.

Why? Because you need to analyze your revenue cycle management performance constantly.

Based on the analysis, you need to make changes accordingly. Assisting the team to handle all the moving parts of the revenue cycle is a mature team leader /manager's expertise.

The manager's expertise is to understand the data that is provided to them. More often than not, data analysis is not their expertise as this requires a completely different skillset.

Invest in these two roles and you will reap the rewards.

What does a revenue cycle manager do?

As mentioned above, your Revenue Cycle Manager will be the overall manager of your revenue cycle. This person will manage all functions of your organization's billing and revenue cycle. They will be responsible to partner with your revenue cycle analyst and understand the data presented to them.

They will be directly responsible for maximizing your healthcare organization's cash flow.

The revenue cycle manager will also be responsible for maintaining and improving internal relations, interactions between the frontend and backend revenue cycle teams.

Your revenue cycle manager will also be responsible for external relations with patients and payers.

This is a senior position and requires having experience by having served in both the frontend and the backend revenue cycle teams.

What does a revenue cycle analyst do?

Your revenue cycle analyst is also a key team member.

Healthcare organizations are usually inundated with data. There's payer-related data, patient accounts-related data, denials data, claims submissions data, and many more.

All these sources of information are brought together by your practice management system.

However, data is just that – data. Unless you are getting actionable intelligence out of your revenue cycle analytics system, there's really no point in gathering all that data.

Analysis of business data is a revenue cycle analyst's job.

Healthcare data is almost always a moving target. Payers, payments, coverage, rules, regulations change all the time. This directly impacts the revenue cycle data and the associated analysis.

Your revenue cycle analyst is directly responsible for partnering with your revenue cycle manager.

The performance and success of your revenue cycle manager depends on the analytics and insights that the revenue cycle analyst provides them.

What is Revenue Cycle Analytics?

Revenue cycle analytics are just a way for you to monitor your revenue cycle processes' performance, issues against the key process indicators that you have defined. More often than not, this is a dedicated technology solution that you purchase from your practice management system or a separate vendor.

Most practice management systems have decent revenue cycle analytics data but what they lack is actionable intelligence. They tell you the data – and that's it. You need a few levels deeper than that. You need to know why those numbers look the way they do, where those numbers are originating from and finally, how to fix those issues.

Start with denials. That's what you are trying to reduce the most and the first.

How do you reduce your denials?

You see the effects of the problems in your revenue cycle in the form of "denials". But that's the effect.

Get to the root cause of all those denials.

Why are those denials happening? This is where data analytics starts to help you.

The first step is to analyze your denials data for the past 12-24-36 months.

OK, so you can export the denials information from your practice management system. Then you run those via a google sheet or a spreadsheet (if you have a small amount of data). So, you run some pivot tables (if you are technically advanced enough) or run some denial data aggregation, grouping etc.

You are finally able to categorize all those denials into buckets (groups). That is, only if you have a limited amount of data that a spreadsheet or google sheet can handle.

You are not going to be able to fix all of them in one shot, but you decide the easiest one first – preventable denials.

Maybe you decide to fix the eligibility issues first.

So, your revenue cycle analyst tells your revenue cycle manager the information and the revenue cycle manager decides to get the team together to fix the eligibility issues in this quarter.

Great.

But, exported spreadsheets are stale the minute you export them.

Your billers fixed the eligibility issues and resubmitted the claims.

They got paid. The minute they got paid, your initial analysis is now obsolete as those numbers have changed.

Hopefully, you put together a great workflow at the frontend revenue cycle team level that prevents these eligibility-related issues moving forward.
How would you know whether your decision was correct?
How would you know that the frontend team is doing their job well?
The only way for you to understand this week after week is to run reports every single week. Isn't it?
This is a moving target. Relying on spreadsheet data just gets you to analytics at a point of time. It is not real time, it doesn't update itself all the time to provide you constant feedback.
What you need is daily feedback.

Top Revenue Cycle Key Performance Indicators – Nearterm

There are several key performance indicators to monitor in your revenue cycle.
However, it is also very easy to get overwhelmed with all the moving parts and all the KPIs.
Start small. Here are some top KPIs to start tracking today (even if you do nothing about them for now).

1. Days in total – discharged not billed. This tells you about your charge lag from when the patient was seen vs when the claim was submitted.
2. Look at your clean claims rate. This will tell you the percent of claims submitted that are clean in the first pass itself (i.e. not denied).
3. Monitor your cash collections at the front desk. This will tell you if you are leaking revenues right at the front desk. This will also help you stay compliant with your payer contracts and MOUs.
4. Track your total A/R and days in A/R. Most practice management systems will come with this information built-in.

Industry standard revenue cycle benchmarks

If you and your team are truly dedicated to being the best revenue cycle team, you will ultimately be looking for industry benchmarks and industry standard key performance indicators.
You can look at both MGMA and HFMA. We like both and you can glean really good information from both. Go ahead and become members of both please.
Keep in mind that HFMA is a membership organization for healthcare finance leaders.
We like their KPIs and their goals – they help to maintain fiscally healthy healthcare organizations.
Check out their certifications CHFP/CSBI/CSAF.
Meanwhile, MGMA is a professional association for medical practice administrators and executives. MGMA is also the source of medical practice economic data and data solutions. They have very resourceful DataDive content. Check out their certifications – CMPE /ACMPE
HFMA has something called MAP Keys.
We use the MAP Keys established by HFMA.

> *"MAP Keys are industry-standard metrics or KPIs used to track your organization's revenue cycle performance using objective, consistent calculations."*
>
> *From HFMA website*

MAP keys are broken down into 5 main areas. There are (as of writing), a total of 29 MAP Keys.

1. Account Resolution KPIs
2. Financial Management KPIs
3. Patient Access KPIs
4. Pre-Billing KPIs
5. Physician Financial Management KPIs

Let's go into each. Do keep in mind that we tend to monitor a few more metrics on the marketing side as well.

Account Resolution KPIs

Accounts are patient accounts. As a services company (which you are), you have accounts that you service and get paid on.
One of the first things that most finance leaders look at after taking over an account's billing (we do the same as well) is to look at the A/R.
What's A/R? Simple – how many patient accounts have you billed for (submitted claims for) and are waiting to get paid on.
If you have not posted charges (claim) for a patent account, you will not make that a part of the A/R.
Why?
Because you cannot get paid for something that you have not billed for.. Yet. That remains in the bucket of "Discharged Not Billed"

Aged A/R as a percentage of total billed A/R

Here, you are trying to measure your effectiveness in collecting A/R.
Your practice management system will typically show you aging buckets of 0-30, 31-60, 61-90, 91-120, > 120 days.
You will look at each bucket. But for this metric, you are looking at the total A/R as well (sum of all those buckets).
As an example, let's say that the total A/R you are due to be paid is $10,000.
Out of ths $10,000, the breakdown might be:

- A/R for 0-30 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for 31-60 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for 61-90 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for 91-120 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for > 120 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- Sum of all %s = 100%.

Points of Clarification:

Make sure you are adding ALL the aging buckets (0-30, 31-60, 61-90, 91-120, > 120 days) from the date of service or discharge.

Make sure that your aging buckets sum up to 100% (of course).

You are only including “active billed accounts” and not the ones where you have credit balance accounts.

Do include recurring accounts that are open.

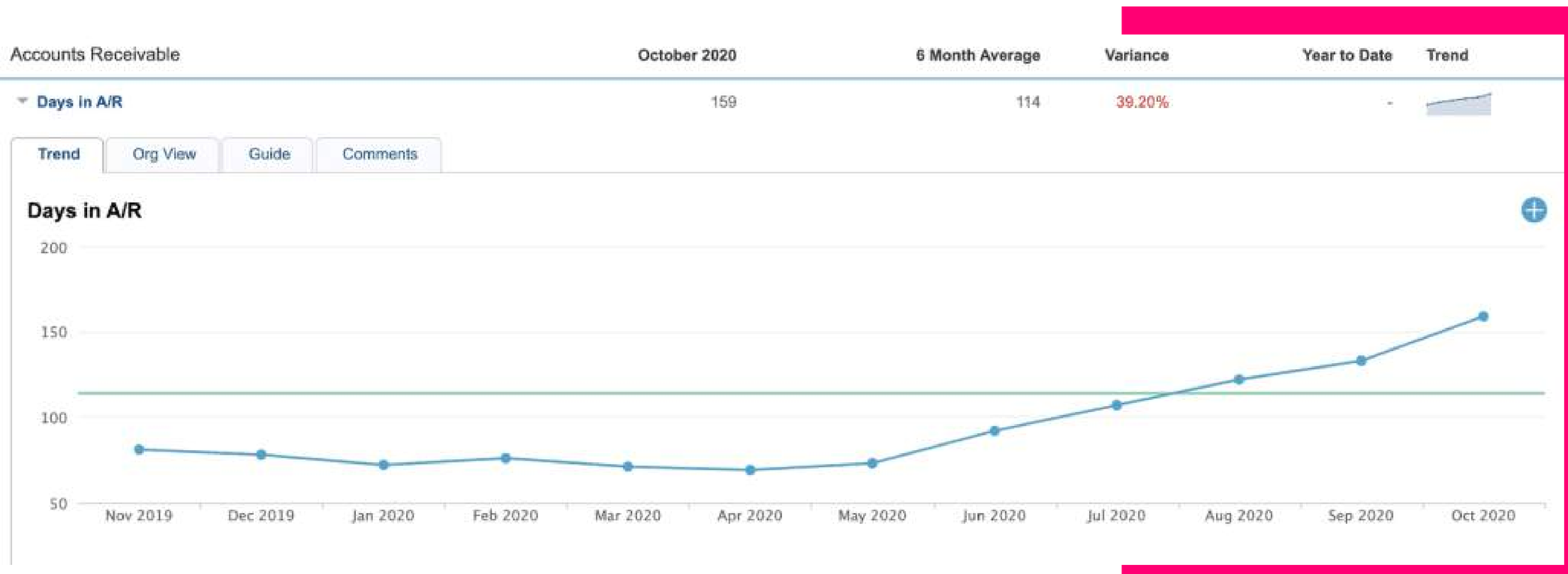
Make sure you include collectibles that are not classified as bad debt accounts yet (you might have outsourced these to a third party as well).

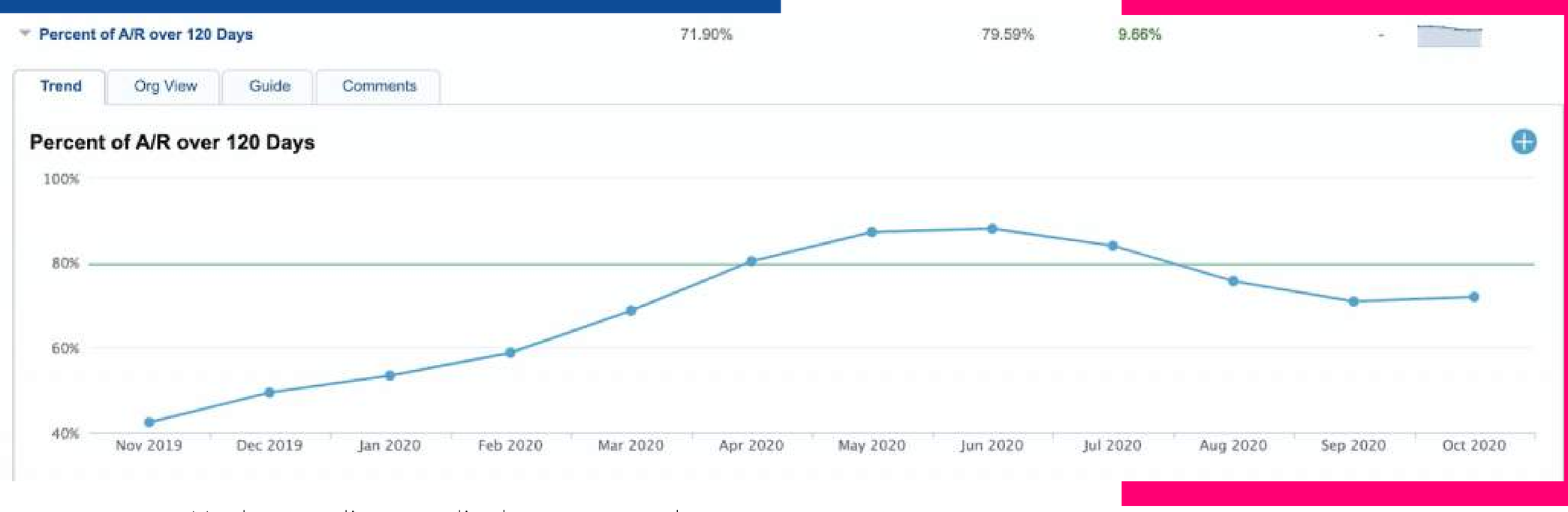
If you have “not final” accounts, do not include them – this includes anything your medical billing team has not yet billed to the payer or patient because these are NOT part of billed accounts receivables.

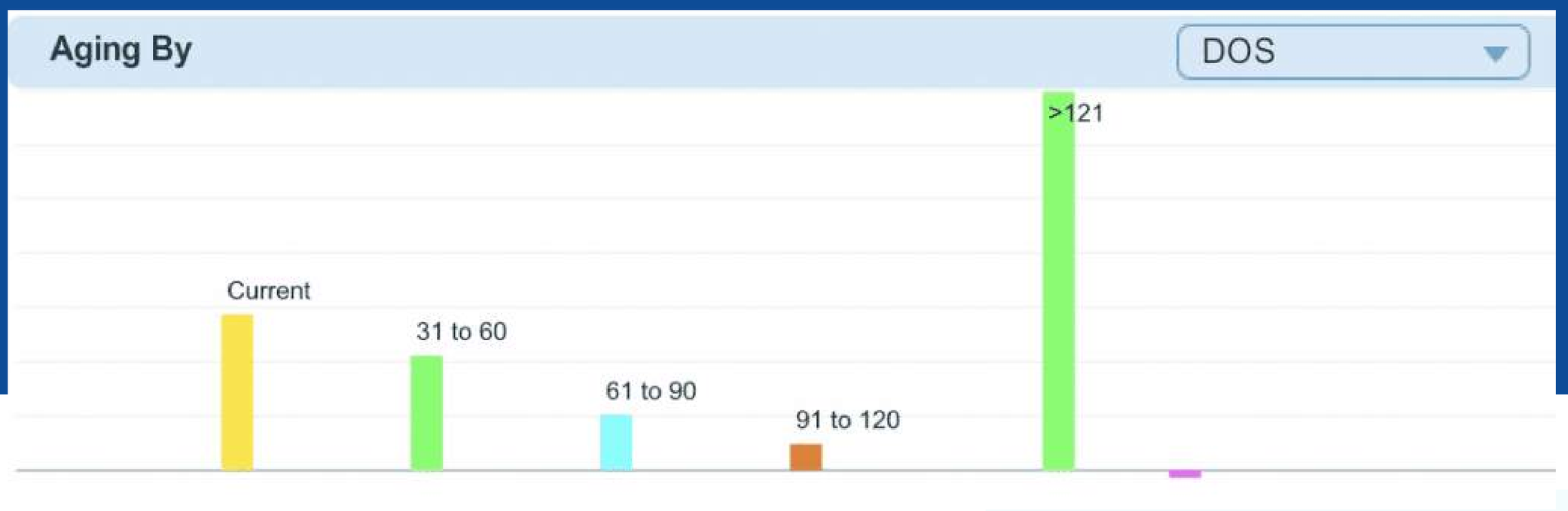
Make sure that you are adding up ALL A/R across ALL payers.

Trend analysis graph

Numbers are great but visuals help a LOT. E.g. see below







See the > 120 days bucket?
That's a red flag.

Aged A/R as a percentage of billed A/R by Payer group

This is very similar to the above, but this shows you the trend analysis of the above data by payer in any reporting month.
This truly helps you to identify issues with specific payers. Some payers are good at reimbursements and some are not. You can identify the problematic payers and group them separately. You might want to assign a separate person or team to that specific payer. This team will start learning the tips and tricks of working with that payer and will guide the frontend revenue cycle management team (and you) better.
As an example, let's say that your total A/R is $20,000.
Out of this, let's say that Healthfirst and BCBS owe you $10K each.
Does this give you enough actionable intelligence? Nope!
Let's say that the total A/R you are due to be paid by Healthfirst is $10,000.
Out of ths $10,000, the breakdown might be:

- A/R for 0-30 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for 31-60 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for 61-90 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for 91-120 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for > 120 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- Sum of all %s = 100%.

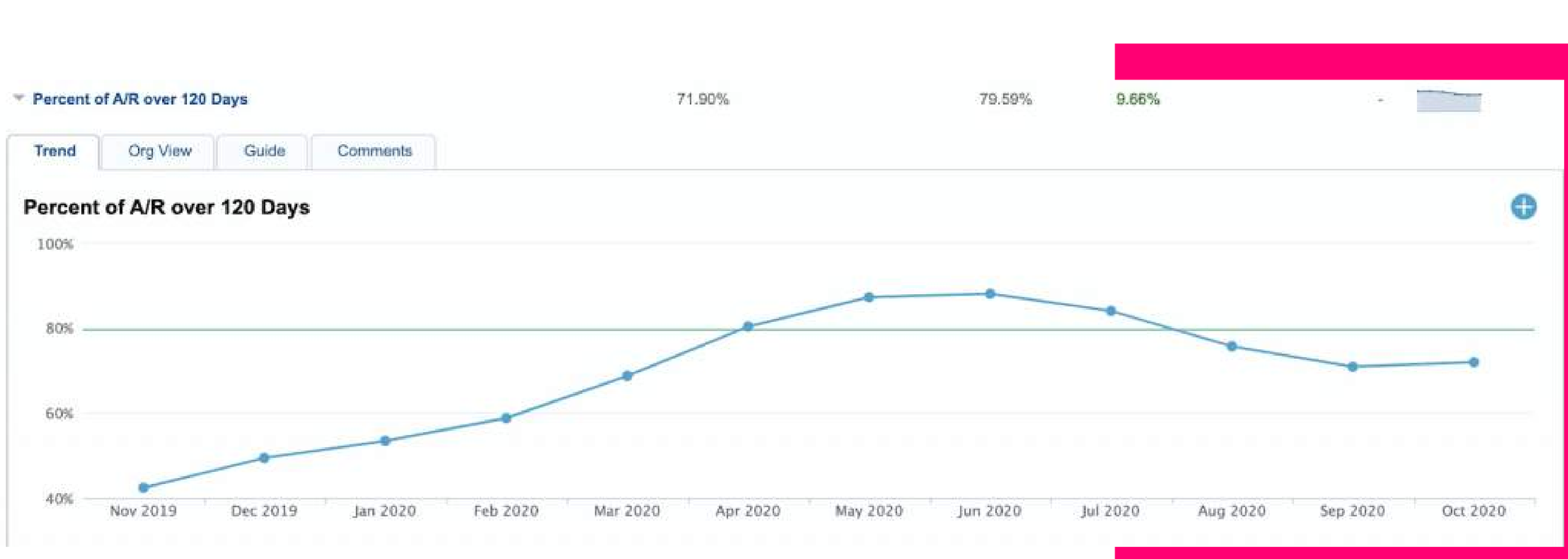
Let’s say the next payer is BCBS (Blue cross blue shield). They owe you $10,000 as well. However, their breakdown might be:

- A/R for 0-30 days – $1,000. I.e. 10% of total A/R ($1,000/$10,000 = 10%)
- A/R for 31-60 days – $2,000. I.e. 20% of total A/R ($2,000/$10,000 = 20%)
- A/R for 61-90 days – $3,000. I.e. 20% of total A/R ($3,000/$10,000 = 30%)
- A/R for 91-120 days – $1,000. I.e. 20% of total A/R ($1,000/$10,000 = 10%)
- A/R for > 120 days – $4,000. I.e. 20% of total A/R ($4,000/$10,000 = 40%)
- Sum of all %s = 100%.

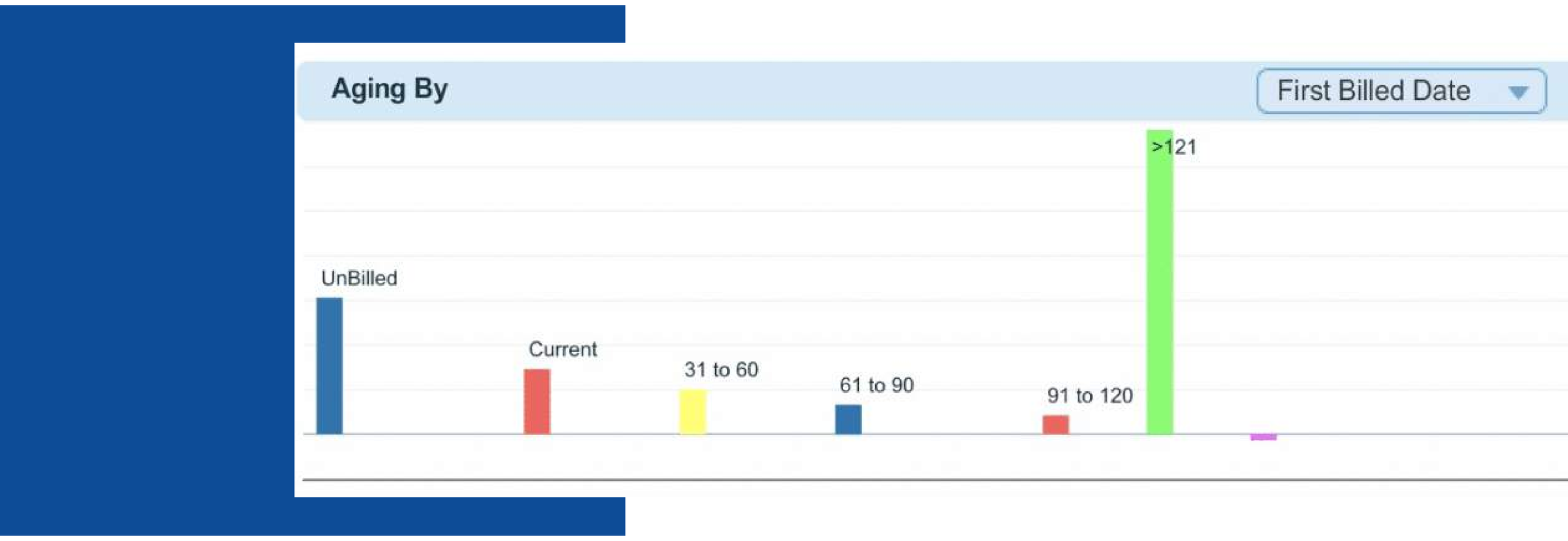
This kind of analysis tells you that there’s a problem in the >120 days aged bucket for BCBS that needs to be addressed asap because this is already very old and the chances of recovering the same are less.

Trend analysis graph

Numbers are great but visuals help a LOT.



You should also view things by first vs last billed date. E.g.



Remittance denial rate

You NEED to know the % of claims being denied by your payers. This will surface MANY cracks in your medical practice's compliance with payer requirements.

For any given month you are simply trying to find the rate of denial.

As an example, if your team submitted $10,000 in claims and got denied for $2,000 of those. Your denial rate for that month would be 20%.

Why do you want to plot it month over month?

To see the trend. If it is trending down, your team is getting better at revenue cycle management. If your team swears that they have been fixing all preventable denials and the trend line is still going up, you realize that there is an issue on the payer's side.

As an FYI, payers are not always correct. Their staff makes mistakes as well.

Do keep that in mind.

To calculate this metric, follow this formula:

Total number of claims denied – this should be in your "Accounts Receivable"

Total number of claims remitted – this is really a sum of your 835 Files and/or Paper Remittance

Points of Clarification for this calculation:

Look at total claims adjudicated monthly at claim level.

Make sure that you are defining "actionable denials".

Why? Because your in-house or outsourced medical billing team can actually do something about it That might end up in reimbursements!

Make sure you are only using those payments that have a denial code on the remittance advice.

Like we mentioned above – first and last submission dates. Take note of that and make sure you are including BOTH initial claim denials and subsequent appeal denial submissions.

You will notice many Zero payment accounts – include those.

You will also find claims that are partially paid. These accounts will typically contain a denial indicator. Include these as well.

Do NOT include denials where plans are denying due to non-covered services. There's nothing "actionable" about it without fudging your claim.

Do NOT include denials where plans are denying due to non-covered services. There's nothing "actionable" about it without fudging your claim.
Do not include Discharged Not Final Billed (DNFB) accounts.. I.e. where your medical billing department has not finalized the claim yet.

Trend analysis graph

Numbers are great but visuals help a LOT. E.g. see below

Financial management KPIs

As per HFMA, there are only 2 KPIs in this.
Net days in A/R and Cash collections as a percentage of Net Patient Service Revenue
These two are pretty simple to handle as well and give you a better handle of your cash performance.

Net days in accounts receivable A/R

You need to know your days in AR stone cold. At any point, you should be able to tell your net days in AR trends.

How to calculate days in A/R (account receivables)

You wait to get paid from the payers and your patients. The faster you get paid, the better it is for you (of course).

Whether you outsource your medical billing or have inhouse medical billers, always know your days in AR. This shows you how well your billing operations are doing (i.e their efficiency).

Here's how you calculate it.

Total A/R year to date divided by the total billing (not collections) per day.

First, calculate your "Total Accounts Receivable".

If you have been following this article, you already did it above.

If you use a blended model of in-house and outsourced billing, add both of these amounts.

If you get any CAH (critical access hospital) payments- add those up.

Add up all your Insurance balances + Patient balances.

From this, deduct any Credit Balances and Collection Agency Accounts.

Next, deduct any charitable amounts. Remove any contractual allowances from any payers that you might have.

Next, take your 12 months of charges (gross charges) and divide it by 365 (days). This gives you your average daily billing / Average Daily Net Patient Service Revenue.

Finally, divide the "Total accounts receivable" by this number.

So,

"Total Accounts Receivable". Add up all your Insurance balances + Patient balances. From this, deduct any Credit Balances and Collection Agency Accounts

— divided by —

12 months of charges (gross charges) and divide it by 365 (days)

How did you do?

Net days in A/R – industry benchmarks

If your days in AR is < 35 – that's GREAT

Days in AR between 35-50 days – you are around the industry average

If your days in AR is more than 50 days – this truly is a RED FLAG and you need to address this immediately.

Keep in mind that this also depends on the specialty we are talking about and the payer mix as well.
You should calculate this per payer as well, to identify problematic payers. There might be an issue with the payer in question. There might also be an issue with your billing department with regards to that particular payer (some process might be missing or misunderstood).
Sometimes you really do not have a choice of payers you want to work with (e.g. in NYC, how do you avoid HealthFirst).
Other times, you can drop a payer from your accepted insurances if you find that they are problematic payers. Or, at the very minimum, bring this up to that payer's provider relationship manager.

Points of Clarification:

Do keep in mind that should not include any A/R related to non-patient specific third-party settlements. Look out for any lump sum payments – we have encountered such lump sum payer payments in the past where a reconciliation project from the past was wrapped up in a year that we were working on those accounts.
If there are any Non-patient A/R, exclude those.
Keep in mind that if you're an FQHC, 340B drug purchasing program revenue is NOT recognized as a patient receivable
You can't include any state or county subsidies.
If you're getting payments for capitation or getting risk based payments- don't include those either.
You can't include ambulance services payments.
For daily billing average / Average Daily Net Patient Service Revenue, you can also use the most recent three-month daily average of total net patient service revenue.
Keep in mind to deduct contractual allowances, charity care provision, and any provision for doubtful accounts.
Keep in mind that you cannot include 340B drug purchasing program revenue if your accounting department has not recognized this as a patient receivable.
Also, keep in mind that you cannot include capitation and/or premium revenue related to value or risk based payer contracts.

Cash collection as a percent of net patient service revenue

This is pretty simple. As you know that your net patient services revenue per month depends on both payers and patient responsibilities.

More often than not, the frontdesk (i.e. front end revenue cycle management team) is not the best at collecting from patients at the time of the patient's visit.

All you have to do is to find out

1. The total patient service cash collected.
2. The average monthly net patient service revenue (you have already been calculating this as above)

Points of Clarification:

You need to deduct refunds from the total patient service cash collected for the reporting month

After collecting cash, there will be occasions where the payment is not distributed. You need to include those as well.

However, you have to exclude non patient cash – e.g. retail pharmacy, optical, capitation etc.

For Average Monthly Net Patient Service Revenue, you can take the year to date calculation we provided above or do a 3 month average. Your choice.

Patient Access KPIs

As per HFMA, there are only 2 KPIs suggested here – both give you ample insights into your frontend revenue cycle management team performance.

1. Percent of patient schedule occupied
2. Point of sale cash collections

Percent of patient schedule occupied

Let's say you have 10 providers that can see 30 patients per day. This means that you have 300 patient appointment slots available per day.

Now, let's say that out of 300 such available slots, the total patient slots booked are 200 (underutilized) or 300 (exact) or 400 (overbooking)

You are trying to calculate the utilization of those available patient slots (ie chargeable events). Measuring this metric will allow you to maximize utilization of your scheduled availability and hopefully, try to maximise capacity utilization.
The calculation is pretty simple –
Number of patient slots occupied divided by number of patient slots available.

Point of service cash collections

Collecting payments from patients after they have left your clinic is hard. And it gets increasingly harder as days progress. You want to make sure you are collecting every penny that's due from the patient, at the point of service, when the patient is right in front of you.
This alone will reduce your collection costs (following up, sending statements, chasing after patients etc).

Calculate the total patient payments made at your frontdesk and divide it by total self pay cash you have collected.
According to HFMA, you can include cash collected up to seven days after the patient is discharged / seen as well. You can also include prepaid cash (e.g. you have a digital patient intake solution that allows patients to pay over the phone / mobile app).
What about payments on patient dues from past visits?
As per HFMA, if you are collecting it prior to this current visit or at the current visit, you can include this as well. However, for prior dues, you cannot include the payment if it is made after this visit.
You have to exclude any payment plan your collections team might have set up. You also have to exclude any cash your frontdesk might have refunded to the patient as well
To calculate the Total Self-Pay Cash Collected, you need to add all the cash collected for patient responsibility for the reporting month. This will include cash collected, all bad debts recovered, any loan payments as well.

Pre billing KPIs

HFMA has only one KPI for this – total charge lag days.
As mentioned before, you need to understand the charge lag days to find out the time spent between the patient being seen/discharged and when the charge is posted.
This alone will tell you several things – including but not limited to whether your revenue cycle management team is adequately staffed or not.
We will never advocate speeding up charge posting just to reduce the charge lag days. It is better to double check your work and take your time to post charges vs posting charges quickly and getting denials.
You pay the piper one way or another. Decide what you can live with.

Total charge lag days

For this, you need to calculate the total days from revenue recognition. You can recognize revenue when you post the charge.
So, let's say you billed 2000 charges in the reporting month and they were broken down like this.
There were 20 service dates in that month where 2,000 patients were seen.
Charges were posted:

1. 400 charges were posted within 2 days of service date
2. 500 charges were posted within 3 days of service date
3. 300 charges were posted within 5 days of service date
4. 500 charges were posted within 7 days of service date
5. 300 charges were not posted in the month of reporting

So, the total charges posted were 1700 (not 2000).
The average is 400*2+500*3+300*5+500*7 / 1700 = 4.29 days
The industry benchmark is 3 to 5 days after date of service or post discharge; So, if you are anywhere close to that, you are doing OK.

Physician financial management KPIs

HFMA breaks this down into primary vs specialty care.

Primary and specialty care practice operating margin ratio

This is simply a calculation of the net income from your primary care practice operations divided by the primary care operating revenue.

It helps you measure the financial performance of a PCP facility.

Net Income From Primary Care Practice Operations is what your PCP practice is making after paying all its expenses. Expenses include everything you need to operate. In other words, include marketing, supplies, salaries, insurance, real estate expenses, building, utility expenses.. All of it.

Meanwhile, Primary Care Practice Operating Revenue is all the revenues from seeing patients / from patient care services.

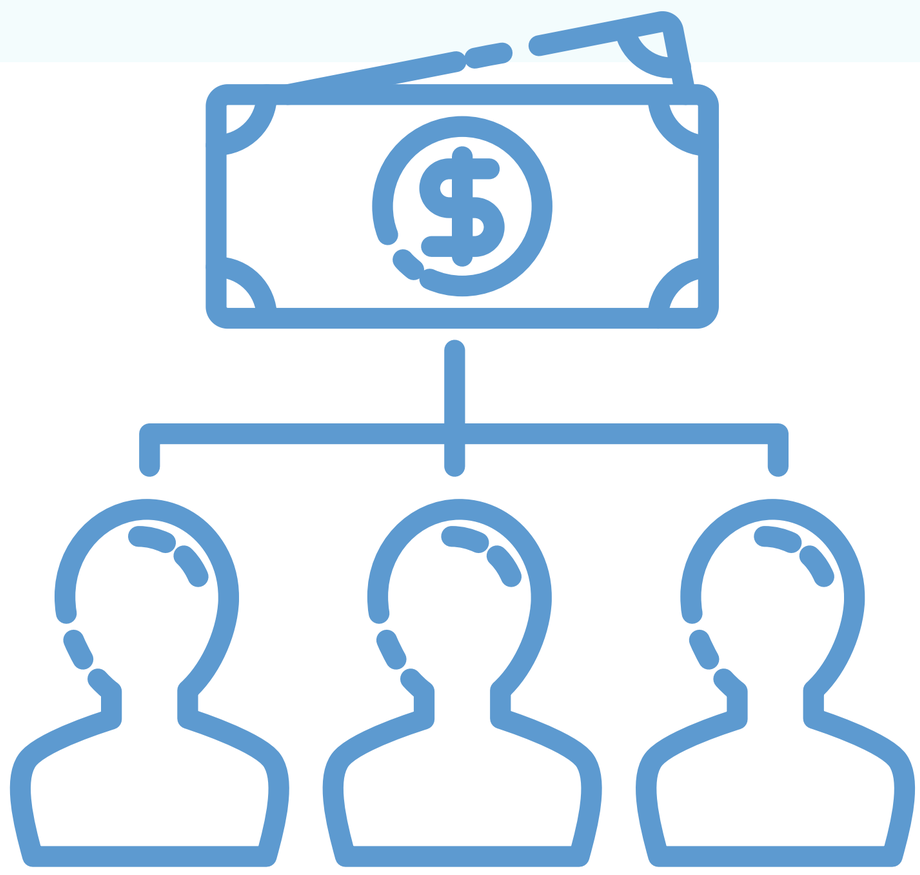
By calculating this, you are effectively trying to understand the operating margins

Net income per primary or specialty care FTE physician

Here, you are trying to understand the profit or loss per full time equivalent physician you have.

Each FTE physician you have, represents an investment – in terms of salaries, support staff, equipment etc.

Calculating this metric will allow you to understand the profitability of your practice on a physician level.



Each FTE physician you have, represents an investment – in terms of salaries, support staff, equipment etc.

Calculating this metric will allow you to understand the profitability of your practice on a physician level.

All you have to do is to calculate the net income from your practice operations and divide by the total FTE physicians you have.

Of course, practice expenses include all operating expenses as explained above.

Be careful when you calculate the total number of Primary Care Practice FTE Physicians. You are calculating a full time equivalent. So, if Dr Jones is getting paid for 20 hours per week – they are 20/40 = 0.5 FTE... not 1 FTE.

Total primary or speciality care physician compensation as a percent of practice operating revenues

Here, you are trying to understand the affordability of a physician compared to the revenues of the entire practice revenues.
Each physician contributes directly to the operating revenues of the healthcare practice. This gives you a measure of their compensation vs their direct contribution.
To calculate this, you take the total physician compensation (include salary/bonus/benefits but exclude the insurance payments) and divide this by the Primary Care Practice Operating Revenue as you calculated above.
These are few of the metrics you need to start with to get a better grasp of your revenue cycle management team and processes.
Once you start monitoring these, you will have the opportunity to dig into further items as well

NISOS HEALTH

UNDERSTANDING MEDICAL REVENUE CYCLE MANAGEMENT 2021 GUIDE

Written by Nisos Health (*nisos.health*)

Want to get started?

Our software and services help providers reduce operational expenses, increase collections, improve patient outreach and patient experience. Healthcare organizations rely on us for call center solutions, healthcare software services, healthcare BPO, medical billing, revenue cycle management solutions.

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