# The Complete Guide to Revenue Cycle Management – A New Comprehensive Course from Manage My Practice

***You spoke and we listened – you asked for a comprehensive course on Revenue Cycle Management and we brought it to you!***

This series is for **anyone** who wants to understand the medical practice revenue cycle from the very beginning to the very end: physicians, physician assistants, nurse practitioners, advanced practice registered nurses, practice administrators, office managers, consultants, vendors, students, coders, billers and those who want a RCM foundation to enter the healthcare field. Anyone who wants to know more about how reimbursement in healthcare works in the medical practice will find this comprehensive series **indispensable.**

**You won't find this comprehensive course anywhere else except at Manage My Practice.** Webinar leader Mary Pat Whaley, FACMPE, CPC has developed this program from 25+ years of experience in medical practice management and from requests she gets weekly for education on the revenue cycle management process.

## The Complete Guide to Revenue Cycle Management – a Five Module Comprehensive Curriculum

### Module I. The Foundation

- Payer Contracting
- Credentialing
- Payer Matrix

- Setting a Fee Schedule
- Understanding Medicare Part B

## Module II. The Data Build

- Practice Management System Set-up
- Allowables
- Patient Demographics & Insurance Information
- Eligibility & Benefits
- CPTs, HCPCS, ICD-9

## Module III. The Pre-Claim Process

- Collecting at TOS
- Documentation: Paper vs Electronic Medical Records (EMR)
- Physician Coding vs. Abstraction Coding
- The Superbill vs. Using the EMR to Bill
- Claim Scrubbing: The Three Gates

## Module IV. The Post-Claim Process

- Write-offs, Denials and Appeals
- Daily Reconciliation Process
- Patient Collections and Payment Plans
- Refunds
- Recoupments

## Module V. Monitoring

- Monthly Reports
- The Practice Dashboard/Snapshot Report
- Strategies for Improving Revenue
- Benchmarks for Staffing
- Revenue Cycle Compliance and Auditing

## Also Included! Action Pack – Handouts in Word/Excel

1. Contract Reference Matrix
2. Contract Review Template
3. Fee Schedule Worksheet

4. Medicare Resources
5. Allowable Cheat Sheet
6. Write-off Approval Form
7. Daily Reconciliation Form
8. Refund Request
9. Monthly Report List
10. Sample Snapshot Report
11. Sample Revenue Cycle Compliance Plan

***Here's what one attendee wrote about a recent Manage My Practice Webinar "Information was right on! Great examples and real life experiences."***

**5-Week Course for $799.00 (Two Options)**

## Option One : Every Tuesday for Five Weeks – March 12, 19, 26, April 2, and April 9

## *Click Here To Register!*

**Module I:** Tuesday, March 12 @7pm ET for 90 minutes

**Module II:** Tuesday, March 19 @7pm ET for 90 minutes

**Module III:** Tuesday, March 26 @7pm ET for 90 minutes

**Module IV:** Tuesday, April 2 @7pm ET for 90 minutes

**Module V:** Tuesday, April 9 @7pm ET for 90 minutes

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## Option Two: Every Thursday for Five Weeks – March 14, 21, 28, April 4 and April 11

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**Module I:** Thursday, March 14 @1pm ET for 90 minutes

**Module II:** Thursday, March 21 @1pm ET for 90 minutes

**Module III:** Thursday, March 28 @1pm ET for 90 minutes

**Module IV:** Thursday, April 4 @1pm ET for 90 minutes

**Module V**: Thursday, April 11 @1pm ET for 90 minutes

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*Mary Pat Whaley, FACMPE, CPC has 25+ years managing physician practices of all sizes and specialties in the private and public sectors. She is Certified Professional Coder, is Board Certified in Medical Practice Management and is a Fellow in the American College of Medical Practice Executives. Mary Pat has been providing free information and resources to physicians, care providers and medical practice executives since 2008. For questions about "The Complete Guide to Revenue Cycle Management" webinar, contact Mary Pat at (919) 370-0504.*

# Collections Basics – Part 1: Know Your Payers

In a traditional healthcare setting, the revenue cycle begins with the insurance companies who pay the majority of the bill. There are multitudes of payers and each payer can have many plans.  How can a healthcare organization catalog this information, keep this information updated and make this information easily accessible to staff so they can discuss payments with patients in an informed and confident way?

Start by breaking your payers into five main categories as a logical way to organize the data.

1. Payers with whom you have a contract
2. Payers with whom you do not have a contract
3. State and Federal government payers (Medicare, Medicaid, TriCare)
4. Medicare Advantage payers
5. Patients

## Payers with whom you have a contract

Your organization has signed a contract with a payer and you have agreed to accept a discounted fee called an allowable, and to abide by their rules.  What is the information you need to collect?

- A copy of the contract
- A detailed fee schedule, or a basis for the fees, such as “150% of the 2008 Medicare fee schedule.”
- Any information about the fees being increased periodically based on economic indicators, or rules (notification, timeline, appeals) on how the payer can change the fee schedule.
- The process and a contact name for appealing incorrect

payments.

- Information on what can be collected at time of service. Hopefully your contract does not have any language that prohibits collections at time of service, but you must know what the contract states.
- Process for checking on patients' eligibility and benefits: representative by phone, interactive voice response (IVR), website or third-party access.

The contract allowables should be loaded into your practice management system so you can calculate the patient's responsibility at check-out and you can identify incorrect payments at the time of check-posting. If your practice management system does not have this feature, you will need a cheat sheet for each contracted payer, showing the most common services, the allowables, and the percentages of the allowables for fast calculation of the patient's portion at check-out. The same or a modified cheat sheet will work for the check posters so they can verify the payer is reimbursing according to the contract.

Your cheat sheet should look like this:

| Plan A | | | | | | | |
|---|---|---|---|---|---|---|---|
| Service | Allowable | 20% | 40% | 50% | 60% | 80% | 90% |
| 99213 | 75.00 | 15.00 | 30.00 | 37.50 | 45.00 | 60.00 | 67.50 |

The check-out staff will write the patient's portion on the encounter form (you may call it a charge ticket, fee ticket, rounding slip, or superbill), add the numbers together and give the patient the total. Alternately, the computer system will total the patient's portion based on the payer and the plan for the check-out person.

The balance of the information collected will be used to develop a payer matrix that might look something like this:

| Payer | Employers | Collectible At TOS | Elig/Benefit Verification | Plan Year | Contract Dates | How to Notify |
|---|---|---|---|---|---|---|
| XYZ | WalMart | Deductible & Co-Pay | website | July-June – | Exp Dec 2013, must neg. <Aug1, 2012 | Call June Jones at 1-800-555-1212 |
| | State Employees | Deductible & Co-Ins. | Website | Jan –Dec | same | same |

Another excellent way your organization can catalog payer and plan information is electronically in a document management system such as **FileConnect,** which I use and recommend.

FileConnect is an electronic filing cabinet with many great attributes, one of which is particularly helpful in this scenario. Every time there is a change in a payer contract, or a new plan is added by a local employer, you can update the staff's spreadsheet tools simultaneously and the newest version will be instantly available on their desktops.

## Payers with whom you do not have a contract

Your primary payers in your community or region will most likely offer you a contract.  Payers with less covered lives will not find it worthwhile to contract with healthcare providers, so you must decide how you will work with these companies and with these patients.

You are not required to file claims with payers that you are not contracted with.  Most healthcare providers do file claims with non-contracted payers to ensure patient satisfaction.  Where providers may differ, however, is whether or not they will ask patients with non-contracted payers to pay in full at time of service, and assign the payment to the patient OR ask the patient to pay only the expected patient portion at time of service and assign the payment to the provider.  This decision will be made as part of your Financial Policy

(covered in Part 2.)

## State and Federal government payers (Medicare, Medicaid, TriCare)

There has been a tremendous discussion in healthcare for the last several years about physicians limiting how many Medicare patients they will see, or even discontinuing to see Medicare patients completely. The rate at which Medicare pays is not enough to support the provision of services in most ambulatory practices, so some physicians do not participate in the Medicare program but still see Medicare patients (the fee they can charge Medicare patients is federally controlled and is called the "limiting" charge) or have opted out of the Medicare program altogether and will see Medicare patients on a cash basis only.

If a practice does accept Medicare patients, whether participating or not, there are set amounts to be collected from patients with Medicare – deductibles and co-insurance, as well as services that are never covered by Medicare.

Make sure that current Medicare allowables for your locality are loaded into your computer to do the math for you. You can use the same type of spreadsheet shown above to develop a cheat sheet of 80% of the Medicare allowable.

| Service | Medicare Allowable | 20% Owed by Patient |
|---|---|---|
| 99213 | 66.74 | 13.34 |

What is confusing to most providers is what an insurance that is secondary to Medicare will pay. Many providers do not collect any fees at time of service for Medicare patients with a secondary payer, as there may or may not be any balance left that is the patient's responsibility.

Medicaid pays less than Medicare does, and based on the very

low fee schedule, many ambulatory providers will not accept Medicaid patients.  Many Medicaid patients must depend on health departments, hospital clinics, federally-qualified health centers (FQHCs) and rural health clinics (RHCs) for care.

Tricare may be accepted on a case-by-case basis.  A healthcare provider does not need to accept the health insurance for retired military across the board, and may decide individually whether to accept a Tricare patient or not.

## Medicare Advantage

Medicare Advantage Plans, formerly called Medicare Choice + and now called Medicare replacement plans or Medicare Part C, are plans offered by non-government payers which replicate Medicare benefits for seniors, sometimes offering enhanced benefits as part of the package.  There are several types of Medicare Advantage Plans, but the main types are local or regional HMO plans which require you to sign a contract, and the Private Fee For Service Plans (PFFS), for which no contract is required.  If you see a Medicare Advantage PFFS patient, you have in essence agreed to accept their terms.  The one thing you should ask prior to accepting a Medicare Advantage PFFS plan/patient, is what percentage and what year of Medicare rates are they paying.

## Patients

So we finally arrive at the payer with whom most healthcare entities have the most difficulties – the patient.  Why is it so difficult to collect from patients?

First, as we have seen throughout this article, insurance can be very confusing.  Without a plan for organizing and sharing information, a healthcare provider may have significant difficulty assessing the patient’s payment responsibility.

Second, it has been a cultural norm until recently that patients do not have to pay at time of service, with the exception of their co-pay, and will be billed for their portion after insurance pays.

We know now that we must collect the correct payment at time of service. This is the only way to reduce the administrative expense of billing the patient for the balance and/or refunding the patient if too much has been collected. This is also the only way to maintain adequate cash flow as much of what used to be paid to the providers from insurance companies has now become the responsibility of the patient. Higher co-pays, higher co-insurance and most of all, extremely high deductible plans have left patients owing much more out-of-pocket and largely being unprepared to pay it at time of service.

In the next part of this series, Collections Basics Part 2: Develop Your Financial Policy, we will discuss setting up your financial policy so both patients and your staff can understand it, and how to collect from patients according to your policy.

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# Four Reasons Why Medical Practices Should Publish Their Fees

1. **Consumers deserve to know what your service costs.** Why would anyone buy anything without knowing what it costs? Consumers should know both the value of the service as well as knowing what is their personal responsibility to

pay.

2. **Publishing fees makes you justify them**. Medical practices may not want to post their fees if they aren't sure what their services truly cost. Other businesses charge what their services or goods cost plus a profit, why don't we?
3. **You will find out if your prices are not competitive in the market.** Patients will tell you. Then you will have to decide if you want to be competitive. If you are worried you can't compete with a hospital-sponsored practice if they know your prices, stop worrying. The hospitals already know your prices.
4. **Publishing your prices will open the door for things to be simpler.** Publishing fees will liberate you and your staff to talk much more openly with patients about their financial responsibility.

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# Guest Author Frank Trew From DataPlus: Ten Ways to Improve Your Bottom Line by Analyzing the Data from Your Practice Management System

***Editor's Note:*** ***DataPlus is MMP's very first sponsor and I want to thank Frank and his crew for their support! If you would like to sponsor this blog and have over 10,000 readers a month see your flash ad, contact me via email at marypatwhaley@gmail.com.***

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The old saying “If you can’t measure it, you can’t improve it” certainly holds true in medical practices today. With falling payer reimbursement it is more important than ever to collect every single dollar your practice is due.

Most practices have sought additional income streams by adding ancillary services. Paying close attention to data can improve decision-making for such services and can dramatically improve revenue without adding any providers or even new patients!

Having ready access to the elusive data within practice management systems can be difficult, but most systems can report the basics. It is imperative that data is trended over a period of time so that trends can be spotted, benchmarks compared, and improvement plans developed. Measuring data and comparing it to the MGMA Cost Survey (find it at mgma.com) is one of the best places to start.

1. **Collection Rates/Ratios:** Two collection rates are measured in medical practices. One is gross collections and the other is net collections, the latter being the most important.

A gross collection rate is payments divided by charges and will depend on an artificial number – how high the charges are set above negotiated allowables – making it not particularly meaningful.

A net collection rate, however, provides a means to benchmark the health of collection efforts. Net collections, simply stated, demonstrate what percentage of collectible dollars (after negotiated contract write-offs) a practice is actually collecting. A net collection rate above 95 percent ””when calculated correctly – denotes a healthy practice.

2. **Denials:** Denials are a significant portion of the cost of running a practice in that services that are provided but not paid for reduce the profitably of those that are. Accurately identifying denials and the reasons for them can help prevent them in the future, thus increasing productivity and lowering

expenses. Identifying denial trends by specific payer or payer group, by CPT code, and by origin ”“ whether at the front desk, with coding errors, or in credentialing ”“ is equally important.

3. **Evaluation & Management (E & M) Bell Curve:** “Overcoding”□ and “undercoding”□ are commonly used terms, but how are they measured? Bell curve trending of E&M data can quickly identify areas where providers may be under coding, resulting in lower revenues, or over coding, resulting in the potential for audits. The difference between a Level 2 and a Level 3 E&M code can mean thousands of dollars in losses per provider per year. Documentation is critical to demonstrating the level of care provided to each patient.

The traditional primary care bell curve below demonstrates that level 3 visits typically comprise about 50% of your established patient encounters, level 2 and 4 visits together about 20% each, and level 1 and 5 visits together about 10%. When plotted on a graph and drawing a line between each, the shape resembles a bell.

4. **Bad Debt:** Bad debt is defined as dollars that could have been collected, but were not. Break this category into controllable factors and non-controllable factors. Issues that you should have been able to control are timely filing write-offs, credentialing errors, lack of follow-up, and incorrect information provided by the patient. Non-controllable issues are bankruptcy, patient failure to pay, and payers retroactively denying coverage due to unpaid premiums.

Reducing bad debt by just two percent can mean tens of thousands of dollars to the bottom line of a practice. The ability to quickly identify bad debt trends facilitates the development of an improvement plan.

5. **AR Days:** AR (accounts receivable) days are a measurement of the average time a dollar stays in an accounts receivable before being collected. The ability to measure, benchmark, and lower AR days provides a means to a significant increase in revenue. Some best practices that reduce AR days are filing insurance daily, sending statements daily, collecting appropriately at check-in and check-out, working denials quickly, discounting self-insured for time of service payment in full, and using an eligibility tool to check every single patient's insurance.

6. **Encounters:** Accurately reporting and separating encounters for most practices is an arduous task of counting fee tickets or using tick sheets. Few practice management systems accurately provide this information. An encounter is much more than a service code. Being able to segregate office encounters from surgical cases, and reporting by payer, time, and location can help identify opportunities for improvement.

7. **Referral Sources:** It is fundamentally prudent for specialty practices to know the origin of patient referrals. This data is rarely reliable or easily created in most practice management systems. Practices need to know not only the source of patient referrals, but also what type of patients (by insurance, by procedure, etc.) are being sent by those sources, and if the referrals from a particular source have increased or decreased over time.

8. **Payer Mix:** It is not uncommon for practices to drop payors due to perception, and not because of actual data or trends. Emotions sometimes come into play and can result in a provider demanding that a payer be dropped because their rates have changed (or other perceptions). This simply does not make sense. Being able to accurately produce and graph data on major payers without hours and hours of work is of high strategic value to a well-planned business decision. It can answer questions about the impact on a practice if a particular payer is dropped, or how those patient slots would

be filled.  Remember to keep adding payers to the practice when feasible; the loss of your largest payer can be minimized if many smaller ones are on board.

9. **Under Payments:** One of the more significant ways to improve a practice's revenue is the swift and accurate identification of carrier underpayments. Identification of underpayments is not simply comparing the payment to an allowable fee schedule.  Practice management systems that have any type of payment audit functionality commonly do not take into account circumstances such as modifiers, or multiple surgical procedures that payers routinely inaccurately apply, causing underpayments.  Having a system to automatically and systematically apply these rules is essential. MGMA states that providers are underpaid an average of six percent of revenue. What does that mean to a practice? The numbers can be astounding to a surgical group, and the identification and collection of those underpayments can be insurmountable.

10. **Fee Schedule Comparison:** It can be difficult to determine what payers are reimbursing by contract for specific codes or ranges of CPT codes. The ability to have immediate and accurate access to this data is crucial in payer negotiations. It is important to remember that the payer already has this information and is betting that the practice does not!

It is now more important than ever for practice managers to have access to the critical information outlined above. It is also important to note that not just any one of the above Key Practice Indicators should be used to determine the financial health of your practice, but all, or a combination of them.

The buzzword among practices today is "Dashboards." The ability to have these Key Practice Indicators in one simple report is proven to increase efficiency, as well as provide a meaningful way to present information to providers. One example of a dashboard is below.

About the author: Frank Trew is the Founder and CEO of DataPlus and  has over 25 years of practice management experience and has served in executive positions in large and small practices. In 1999, as the COO of a large orthopaedic group in Nashville, he was frustrated by an inadequate access to data that limited his ability to measure and improve the bottom line. The development of a data warehouse was the solution.

In 2000, after hearing how this data was a key practice management tool, many of Frank's peers also wanted to use it improve their practices. DataPlus was formed as a result and has been providing MegaWest, HealthPort, and Centricity users with this unique tool ever since.

Employing a simple to use "point and click, drag and drop" reporting tool, along with an advanced Contract Management and Revenue Recovery System, DataPlus provides key management data across all specialties and throughout the United States.

Frank invites readers to visit the DataPlus website at www.mydataplus.com. Frank may be contacted via email at ftrew@mydataplus.com or by telephone at (888) 688-3282.