WHITEPAPER

Hold On to What You Earn

8 Tips to Better Manage Your Revenue Cycle

PRESENTED BY:

nextgen healthcare

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Find opportunities in challenges

Efficient revenue cycle management (RCM) is the linchpin for financial success. But for medical practices, the revenue cycle journey is fraught with risks.

Manual RCM workflows consume valuable time and carry a high likelihood of error—and errors are likely to result in denied claims and unpaid balances. Without automation of billing processes and deep specialty-specific coding expertise, your practice risks leaving money on the table.

Revenue prediction has gotten more difficult, especially in the aftermath of in-person visit volume fluctuations during COVID-19. A McKinsey study found that outpatient visit volume dropped 15% in 2020 but would exceed the 2019 baseline by 7% by the end of 2021.[1] However, the Commonwealth Fund reported that pediatrics, rehabilitation, and behavioral health specialties have yet to return to their pre-pandemic baseline.[2]

Amid these challenges, there's opportunity. Your practice can streamline revenue cycle management to enable faster payment and reduce claim denials. Check out these eight tips.

1. Get more patients through the door and provide a better experience

Take steps to improve your patient experience. Whether it's new workflows for office staff, new technology tools to enhance patient engagement, or a combination, providing better patient experience can improve RCM.

Here's four ways you can enhance the patient experience:

- Leverage automated phone, SMS, and email appointment reminders to facilitate communication and reduce no-shows
- Implement online bill payment, appointment scheduling, and prescription refill capabilities to make it easier for people to do business with your practice and reduce the need for them to make calls
- Use an operational analytics solution to identify booking trends, such as utilization rates for specific dates, then use this information to increase your bookings and optimize your schedule (for more on analytics, see page 7).
- Offer payment plans to make it easier for patients to pay for services—this will also help reduce days in accounts receivable (A/R)

2. Improve accuracy of information communicated to payers

Efficient revenue capture depends on inclusion of accurate information with claims sent to payers. Typically, 85% to 95% of claims are either paid on the first pass or prompt an action to redirect the collection to a secondary payer or the patient. The remaining 5% to 15% of claims are denied.[3]

Many types of errors cause denied claims—most errors are preventable. One best practice is to verify a patient's demographic and insurance coverage information at the time of visit.

Pinpoint patient insurance info

When the patient tells your staff their insurance provider, make sure the exact plan is communicated. Failing to pinpoint the specific plan may cause you to miss filing deadlines and can create significant roadblocks to payment.

For example, if the patient has Medicare, ask if they have a red, white, and blue Medicare card or is Medicare written on another insurance card (for example, UnitedHealthcare). If the latter, the patient has a Medicare Advantage plan. If the patient has Medicaid, determine if it's a Medicaid managed care plan.

Check provider info from the payer's perspective

Make sure the insurance payer has accurate provider information. Identification of the physician as out-of-network is a common cause of denials.

Each healthcare provider affiliated with your practice needs to be properly credentialed and connected to the appropriate group for billing purposes by the insurance company, especially if your practice contracts out some professional services. For billing to go smoothly, each doctor needs to be properly attached to your group from the insurance company's perspective.

A national provider identifier (NPI) number is a unique 10-digit identification number issued by CMS to health care providers. The NPI is a required physician identifier for Medicare services and commercial healthcare insurers. Each individual physician has their own NPI. In addition, every group practice has its own NPI. Out-of-network denials may result if NPI and tax ID information is mismatched; for example, if an individual provider's NPI number is not associated with the Tax ID of the medial practice billing for services by the insurance payer.

Consider automated uploads

Your practice can also authorize payers to upload records directly from the EHR. As the Journal of AHIMA points out, this speeds up claims processing and reduces administrative burdens. However, payers can also conduct post-payment audits and risk adjustment reviews that are of little financial benefit to practices – and could in fact result in denials or recoupment of funds already distributed. Practices that allow payers access to their EHRs must weigh these risks and should consider implementing policies that restrict what information payers can access.[4]

3. Automate management of prior authorizations

Payers that require prior authorization for medications, procedures, or medical services add to your administrative burden and create financial risk. Without prior authorization, claims may be denied. Either your practice or the patient may have to foot the bill.

Using prior authorization management software helps cut down on these errors. It saves time, simplifies workflows, reduces the amount of paper required to track authorizations, and ultimately decreases denials. Listed below are functions of prior authorization management software:

- Review claims prior to submission to identify when an authorization is required
- Automate the process of requesting authorization electronically
- Track the status of an authorization request.
- Scan payer websites for prior authorization requirements, saving staff time needed to search individual websites for this information.
- Provide office staff with a worklist of authorizations that have been approved, denied, or require additional documentation.
- Enable staff to validate authorizations using electronic workflows and then prepare claims for submission.
- Alert staff of missing authorizations before claims are submitted

4. Empower staff to optimize efficiency

With attention often focused on payers, many medical practices fail to consider the possibility that their own staff may struggle to understand and implement billing procedures, practice management (PM) software, or both. For example, software may not set up properly or staff may not understand how to use it well enough.

Three things must happen for a medical practice system to run efficiently:

1. Collect complete and accurate patient demographic and eligibility information upfront
2. Get charges coded and entered into the PM system
3. Send out claims

Here are steps you can take to mitigate issues with billing procedures and PM software:

- Make sure your PM solution is running optimally and take steps to ensure that staff understand how to enter charges and use the software to generate and send out claims.
- Go digital—all the way. Encourage clinicians and staff to enter all billing data into the EHR.
- Ensure physicians sign off in a timely manner. Until an encounter is signed off in the EHR, you can't start the billing process. A friendly reminder to providers to sign off can help.
- Save time with a mobile solution. Capture information about diagnoses and procedures faster and more accurately with a mobile solution that allows physicians and other staff to dictate notes on-the-go using a smartphone. Built-in voice dictation and transcription make it easier and more convenient to record details about patient visits and capture charges. Look for a mobile solution that integrates with your EHR.
- Increase accuracy with a certified coder. Medical coding standards are increasingly complex. A certified medical coder is trained in these regulations and requirements and is better prepared to translate physicians' reports into accurate medical codes.
- Make sure charges are billed promptly according to your practice's needs—usually within three to five days. The sooner claims are submitted, the sooner your practice will receive a response from the payer. This in turn allows more time for your practice to respond. For example, you may need to submit additional documentation or, if a claim is denied, file an appeal.
- Reduce the timeframe for holding unpaid charges in accounts receivable. Allowing these charges to sit for months at a time affects the revenue stream. Establish clear policies for when to write off charges or send them to collections.

5. Automate the charge review process

Charge review is the process of verifying the accuracy of charges when a claim is generated in an EHR system and transmitted to a PM system. A charge review rules engine automatically checks the accuracy of coding before claims are imported into the PM system. This includes verifying charges against specialty- and practice-specific requirements.

A charge review rules engine can automatically compare charges against standards set by Medicare, Medicaid, and private payers. This makes it possible to identify discrepancies in charges or billing codes in claims going to a specific payer without the need for a time-consuming manual review.

A charge review rules engine brings a new level of automation to the revenue cycle. It increases efficiency and prevents denials.

6. Identify patterns in denials and address them

Consider a situation where accounts receivable (A/R) days are increasing. You've looked at your billing process to assess whether charges are entered and claims sent out in a timely manner. As a next step, get a better grasp on payer behavior by examining denial patterns.

First look at whether denials are going up or down month-by-month. Then investigate which types of denials have the greatest effect on your practice's financial performance. Assess your most common reasons for denials—coding errors, errors in patient demographics, failure to obtain proper preauthorization, noncoverage by the insurance plan, lack of medical necessity, or one of many other possible reasons.

Individual denials must be addressed on a case-by-case basis. However, understanding denial trends can help improve policies and educate staff. Share information on denial volume and root causes within your practice to minimize repeat errors.

7. Take advantage of financial and operational analytics

Your practice can benefit from an analytics solution that provides a view of key performance indicators (KPIs) at a glance. An analytics tool will leverage dashboards and visualizations to help you quickly spot trends in your practice's financial performance and in ongoing operations.

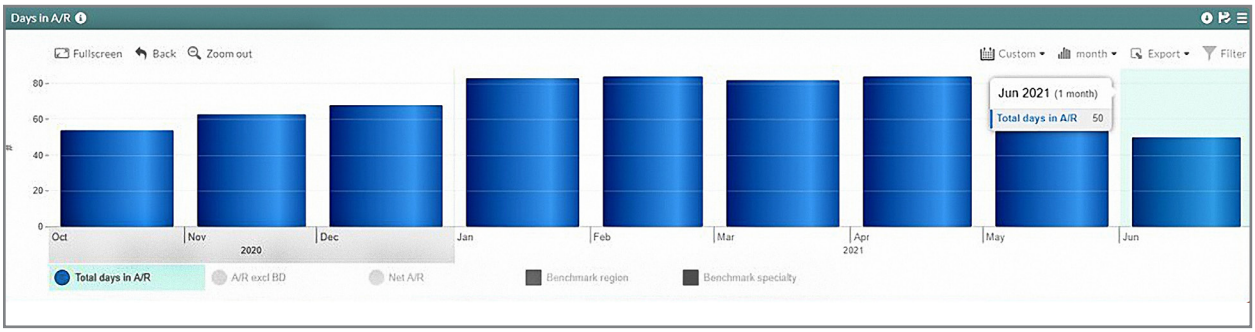
Analytics is different than standard financial reporting. In financial reporting, information is presented as raw, uninterpreted data. By contrast, analytics is the presentation of data that has been filtered or processed so you can interpret it more readily.

Financial and operational analytics offer the means to get quickly and easily to the insight contained within rows of numbers. Many times, using analytics eliminates the need to run reports or create Excel spreadsheets and spend hours analyzing data.

Visual presentation is an important aspect of data analytics. Visualization guides your attention to see trends quickly. You can see immediately if you meet established benchmarks.

Because trends are understood more readily, you may find it easier to take action on insights. Financial and operational analytics can support continuous improvement in how you run your medical practice.

Example of Financial Analytics: Total days in A/R



Total days in accounts receivable (A/R) is a critical indicator of business performance. This visualization helps you track and trend A/R over a specified period of time. This analytics solution also provides drill down capabilities for a closer, more detailed review.

8. Find an RCM partner with experience in your specialty

Partnering with an RCM services provider can help your practice optimize the revenue cycle and increase collections by providing access to greater expertise and superior technology for managing finances. Consider contracting with an RCM services provider especially if talent recruitment and retention is a major barrier to optimal RCM. An RCM services provider can help to alleviate the demands of building a large internal billing team.

If you are considering an outsourced RCM services provider, assess each candidate's experience. The experience brought by the RCM services provider and knowledge of your practice's specialty is extremely important. As examples: An RCM services provider that provides support for an orthopedic practice should have expertise in orthopedic billing, A/R, and denials. A RCM services provider for an ophthalmology practice should have expertise in ophthalmology billing, A/R, and denials.

A thorough understanding of your specialty helps avoid leaving money on the table. For example, an RCM partner should know how to code and bill for frequently administered specialty drugs. More generalized RCM service providers may not know how to maximize reimbursement.

A partner, not just a vendor

The right RCM services provider will be able to achieve a faster, more effective revenue cycle by identifying missed revenue opportunities, preventing denials, increasing net collections, and reducing days in A/R. This will help improve the patient experience as well as lower cost for your practice.

Practice leaders need to ensure they have a partner, not just a vendor, to ensure long-term success. The right RCM partner should have the capabilities needed to support future growth in the face of common challenges, such as a volatile healthcare economy, constantly changing payer rules, and new state and federal requirements for medical billing.

Getting Results

A trusted RCM partner can turn RCM into a strength for your practice, while enabling your plans for growth and care delivery. NextGen® RCM Services serves more than 6,000 ambulatory providers across the United States and manages more than 12 million claims per year.

Results experienced by healthcare practices tell the story.

Palmetto Retina Center

Columbia, South Carolina-based provider of medical and surgical care for patients with serious retina conditions

PROBLEM

Palmetto Retina Center was experiencing a slowdown in reimbursement for medications. This meant that the organization was paying for costly injections, corticosteroids, and other medications out of its own funds – and, in some cases, writing off charges.

SOLUTION

Palmetto Retina Center replaced its existing RCM vendor with NextGen RCM Services, complementing the organization's use of NextGen® Enterprise EHR and PM. This brought increased automation across the revenue cycle, ensuring that claims were billed at the contracted amount, coded accurately, and processed as quickly as possible. In addition, Palmetto Retina Center gained greater insight into financial data and KPIs such as payment patterns, unpaid claims, and denials.

RESULTS

With NextGen RCM Services in place, Palmetto Retina Center has achieved a rate of 95% of claims paid within 60 days. In addition, denials dropped 30%, from 8.67% to 6.13%, and charges increased nearly 14% compared to the organization's experience with its previous RCM vendor.

Karing Hearts Cardiology

Independent cardiology practice with three locations in Northeast Tennessee

PROBLEM

Karing Hearts Cardiology had outsourced billing to a third party. Cash flow was unsteady and unpredictable. Month-to-month revenue shifts were sometimes as high as 50%, which made it difficult to accurately predict revenue and implement business planning.

SOLUTION

Already a NextGen Enterprise EHR and PM user, Karing Hearts Cardiology implemented NextGen® Financial Suite Pro to manage billing as well as NextGen® Managed Cloud Services for software hosting. They quickly began to see increased stability and consistency in cash flow. Automation enabled the practice to expedite submission of charges to payers. Charges were submitted daily instead of weekly.

RESULTS

Karing Hearts Cardiology increased month-over-month revenue by 10%. They reduced monthly revenue shifts to 5% from the previous high of 50%. The organization also improved the accuracy of coding for cardiac positron emission tomography (PET) scans, allowing for appropriate payment and increased revenue.

Reno Sparks Tribal Health Center

Health clinic owned and operated by the Reno-Sparks Indian Colony Tribal Council (Paiute, Shoshone, and Washoe nations) in northwest Nevada

PROBLEM

Reno Sparks Tribal Health Center struggled with financial management. Claims took as many as 40 days to be created, and the business office only received paper payments, which sometimes took weeks to process. This led to an average time for claims payments of more than 180 days and an outstanding A/R balance of about $3.8 million. Charges were frequently adjusted and voided as well. Financial concerns left the future of the clinic in doubt.

SOLUTION

Reno Sparks Tribal Health Center implemented NextGen RCM Services in May 2020, with a core focus on automation for processing payments. From 80% to 90% of payers were moved to electronic funds transfer and electronic remittance advice. In addition, the clinic's business office worked closely with a NextGen Healthcare client manager to develop billing best practices.

RESULTS

Increased automation made a huge impact on Reno Sparks Tribal Health Center finances. The clinic has reduced outstanding A/R by more than 47% (to less than $2 million), cut the average time for claims to be paid as much as 3x, and increased the gross collection rate for adjudicated claims from 34% to 63%.

South Bend Clinic

Group practice based in South Bend, Indiana with 150 providers in 30 specialties across 10 locations

PROBLEM

As part of its transition to value-based care, South Bend Clinic sought more accurate risk adjustment factor (RAF) scores, which are used by CMS to adjust payments. The organization had determined that its RAF scores did not match up to its patient population. Patients were sicker than the RAF scores indicated, which meant South Bend Clinic was missing RAF revenue.

SOLUTION

Using the NextGen® Charge Review Rules Engine, South Bend Clinic began to automate the review all value-based encounters before claims were filed to ensure accurate hierarchical condition category (HCC) data was captured and submitted. The process of capturing accurate HCC data before filing claims led to improved RAF scores.

RESULTS

South Bend Clinic increased the average RAF score by 34%. The organization also captured more than $500,000 in additional RAF value in less than two months. They realized payback on their software investment within one month of implementation.

BETTER STARTS HERE.

Contact us at 855-510-6398 or results@nextgen.com.

NextGen RCM Services

To help your practice achieve a faster, more effective revenue cycle, NextGen® RCM Services uses both sophisticated technology and an expert professional team:

- Your practice's specific needs are addressed by a dedicated client manager with expertise in your practice specialty.
- Core functions—including claims submission, payment management, and credentialing—are centralized and managed using a centers-of-excellence approach.
- Routine tasks are automated. You can automate reports and statements; billing; claims; collection and recall letter generation; eligibility and claim status requests, and more.

All this will make a huge difference in the financial viability and long-term success of your practice.

1 McKinsey's Healthcare Systems & Services and Public & Social Sector Practices, "Survey: US hospital patient volumes move back towards 2019 levels." McKinsey, Nov. 24, 2021. **2** Morgan Frey, "US hospital outpatient volumes show stability in face of late COVID-19 surge." S&P Global Market Intelligence, March 3, 2021. **3** "Improve Practice Efficiency: 7 Revenue Cycle Best Practices." NextGen Healthcare, 2020. **4** Greg Ford and Rita Bowen, "Payer Access to EHRs: What Providers Need to Know." Journal of the American Health Information Management Association, Oct. 19, 2019.