Revenue Cycle Management

Streamline and Automate Your Practice's Revenue Cycle

CME CREDITS: 0.5

Heather McComas, PharmD
Director, Administrative Simplification Initiatives, American Medical Association

How will this module help me?

1. Guidance on streamlining and automating revenue cycle functions.
2. Downloadable tools for implementation and optimization.
3. Support for establishing a successful patient payment program.

Introduction

Revenue cycle management refers to the business side of your practice–from verifying patient insurance eligibility to submitting claims to receive health plan payments and billing patients for their share of service payments. Although patient care will always be your top passion and priority, an efficient revenue management system is critical for your practice's financial health and sustainability. Electronic methods can streamline revenue-related processes like eligibility checks, claims submissions, and payments—allowing your practice to maximize the amount of time available for patient care.

The Eight STEPS that follow assume you will oversee revenue cycle management. If you decide to outsource that function to a 3rd party vendor, you still need to be aware of the functions in RCM as you may be held responsible for billing abuse/fraud in your practice.

Eight STEPS to Improve Revenue Cycle Efficiency

1. Select the Right Practice Management System (PMS) for Your Needs.
2. Verify Insurance Eligibility Electronically Before Every Patient Appointment.
3. Reduce Prior Authorization Burdens Through Electronic Transactions.
4. Submit Claims Electronically to Save Time and Money.
5. Determine the Status of Your Submitted Claim.
6. Leverage Electronic Remittance Advice (ERA) to Simplify Processing of Payment Information.
7. Review Electronic Payment Options and Make an Informed Choice for Your Practice.
8. Maximize Collection of Patient Payments.

1   Select the Right Practice Management System (PMS) for Your Needs.

As with any technology selection, the "right" PMS for your practice is the one that will best meet your team's needs. Whether you are purchasing your first PMS or changing to a different product, first turn your attention inward to your practice. Soliciting input from all team members who use and interface with a PMS and including them in the selection process will ensure that you pick a vendor and product that matches your practice's priorities and needs. A thorough analysis of your practice's revenue cycle process and workflow will provide valuable insight into your system's requirements. Additionally, this type of analysis will help to identify opportunities for automation through the PMS that will improve the efficiency of your practice.

Once you've determined who should be involved in the decision-making process and how your practice manages revenue cycle functionalities, it's time to list and rank key PMS capabilities and features as a team. This checklist will establish the essential features ("must haves") for your PMS, as well as desirable but not required features ("nice to haves"). The following sample checklist of PMS criteria can help you start thinking about the PMS capabilities that are of highest priority for you and your team.[1]

Practice Management System Criteria Checklist
(MS-WORD, 47 KB)

One important factor to consider when selecting a new PMS is how well the product will integrate with your electronic medical record (EMR).[2] In many cases, physician practices choose to replace both their PMS and EMR at the same time. Identifying an integrated PMS/EMR product from the same vendor may provide the most seamless collection and use of administrative and clinical data. Practices simply replacing their PMS should ensure that this new software can appropriately be integrated with the existing EMR. For more information and resources on how to choose the right EMR for your practice, see the **EMR/Electronic Medical Record software selection** and purchase module.

After you've determined the most important PMS features for your practice, you can begin researching various vendors and products in order to compare their functionalities against your practice's priority checklist, assess their training and support services and identify your top candidates. The next step is to create a formal request for proposal (RFP) that outlines your practice's PMS requirements and evaluates the vendor's ability to meet these needs and at what cost. Use the RFP template below to create a document your practice can use to formally solicit cost and capability information from your "finalist" PMS vendors.

Sample RFP
(MS-WORD, 90 KB)

The RFP responses will provide the data you need to make an informed PMS selection for your practice. Once you've reviewed your options and made a choice, you can move forward with PMS implementation. When you are up and running with your new PMS, you will be ready to leverage this technology and begin using electronic processes for revenue cycle management.

2 Verify Insurance Eligibility Electronically Before Every Patient Appointment.

Unfortunately, the following scenario has probably happened in your practice: your team learns that a patient was not covered by a health plan or has an out-of-network plan after a service has already been provided. You and your patient now both face the unwelcome challenge of addressing a surprise bill that is potentially higher than the patient can afford.

This situation can be avoided by verifying patient eligibility before all patient appointments. Obtaining a Medicare Notice to Beneficiary before a non-covered service is provided is important to allow billing of the patient.

Ideally, this eligibility check should be performed electronically. Although most health plans allow patient eligibility to be verified over the phone or via a health plan web portal, the efficiency and accuracy of these methods vary between different insurance companies and their products.

Using the information from the patient's health plan member card, submit an electronic eligibility request by entering patient data (often some combination of member ID, last name, first name, and date of birth) and a service date into your PMS. The electronic eligibility request can be used to request either high-level benefit information or more specific data, depending on your needs. A general health plan coverage inquiry will return information about a patient's medical, chiropractic, dental, hospital, emergency services, pharmacy, physician office, vision, mental health, and urgent care benefits. In addition to indicating the patient's coverage, the electronic eligibility response also provides information regarding any co-pays, co-insurance, or patient-specific remaining deductibles. This information is crucial to collecting payment from patients at the point of care (see Step 8).

Q&A ---

When is the best time to run the eligibility check?

Eligibility should be verified before the patient's appointment. Some practices find that running "batch" eligibility checks a week or two in advance of scheduled appointments is an effective method for identifying patients who have expired insurance information on file or for whose plans your practice is out of network. These patients can then be contacted to obtain new insurance information, or team members can initiate a discussion regarding anticipated out-of-pocket expenses. This also prevents the situation where a patient arrives for an appointment with an out-of-network physician or with limited coverage for a scheduled visit.

Ideally, if a patient calls to schedule an appointment or makes an appointment online in the near future, the scheduling or registration team can collect the patient's insurance information and run the eligibility verification in real time. Federal regulations require health plans to respond to electronic eligibility inquiries within 20 seconds. Patients can then immediately be made aware of any financial responsibility that will be requested at check-in.

3 Reduce Prior Authorization Burdens Through Electronic Transactions.

Your practice has no doubt experienced the administrative burdens and delays in care associated with health plans' prior authorization requirements. The American Medical Association (AMA) believes that prior authorization is currently overused and urges health plans to limit use of these programs to true utilization outliers, instead of broadly applying coverage restrictions to all practices.

Recognizing that health plans will continue to use prior authorization for the foreseeable future, the AMA urges the health care industry to move towards automated processes. Newly available electronic pharmacy prior authorization transactions enable physicians to complete prior authorization requirements as part of the electronic prescribing workflow. Ideally, a physician will be aware of drug prior authorization requirements before sending a prescription to the pharmacy, which minimizes the chances of patient medication nonadherence. Electronic prescribing system vendors are in various stages of implementing electronic prior authorization technology. Find out your vendor's timeframe for electronic pharmacy prior authorization implementation and request this new technology for your practice.

Q&A ---

How can we reduce the physician time spent on prior authorizations?

In a **team-based care** model, the physician's team can complete most of the patient visit documentation and take on much of the work associated with administrative tasks, such as prior authorizations, that take up valuable physician time. Review the **team-based care** module for more information about sharing administrative work with non-physician team members and to determine whether this model could work for your practice.

4 Submit Claims Electronically to Save Time and Money.

Health care claim submission used to require a cumbersome, manual process of completing a paper form, mailing it to a health plan and waiting—sometimes weeks—for a response. Practices that submit claims electronically save time, eliminate postage and other mailing expenditures and can more easily track a claim's status. In addition, electronic claims submission often speeds health plan adjudication and payment.

After your PMS generates an electronic claim, your practice can either submit it directly to the health plan or, more commonly, indirectly through a clearinghouse or billing service. If using one of the latter, know the fees that a clearing house or billing service will charge you for each submitted claim.

Your PMS, clearinghouse and/or billing service may pre-audit or "scrub" claims prior to submission to the health plan to check for missing or incorrect information. These built-in checks allow any potential issues to be addressed before the claim reaches the health plan's adjudication system, thereby reducing payment delays and denials—another advantage of electronic claims submission. Contact your vendors for more information regarding the specific issues for which they screen as part of their claims pre-audit process.

5   Determine the Status of Your Submitted Claim.

Typically, practices do not know if their claim has been received by the health plan until it is paid, marked pending, or rejected. While some health plans and some clearinghouses offer an acknowledgement transaction to confirm that a claim has been received, this is not currently required by federal law, although some states may require such acknowledgement. To address this issue, many practices utilize an electronic claim status inquiry to confirm receipt of submitted claims, as well as to determine claim status.

Health plans are required to support real-time claim status processing. Similar to electronic eligibility inquiries, practices can also send "batch" transmissions to health plans to check the status of multiple claims at the same time. It is important to check with the health plan if one claim submitted in a "batch" that the plan has questions about will hold up payment for all others.

By law, the practice must receive a response by the next business morning, although some practices report receiving these responses much sooner. Rather than waiting two or more weeks before taking action on a submitted but unadjudicated claim, utilizing the electronic claim status request provides the practice with an immediate status report on the claim. The practice can then fix a problem, resubmit the claim, and lower the days in accounts receivable.

6   Leverage Electronic Remittance Advice (ERA) to Simplify Processing of Payment Information.

Reviewing and interpreting paper-based claims remittance information can be a real challenge for physician practices. An ERA is an electronic version of a paper explanation of benefits (EOB). Like a paper EOB, an ERA provides details about the amount billed, the amount being paid by the health plan, and the reasons for any differences between the billed and paid amounts. Manual reconciliation processes and sifting through stacks of paper EOBs can be sizable administrative hassles. The standardized ERA offers a way for practices to reduce these burdens, more quickly identify those claims that require reworking, and generally allow team members to spend more time on higher-value activities.

The ERA uses standardized codes to express everything from the status of a claim to messages about reductions or increases in payment. This allows the practice team to review an ERA from any payer and understand the message without needing to look up the meaning of each payer's proprietary codes. It also enables a vendor to program the PMS to automate ERA-processing across payers.

When implementing ERA in your practice, you will need to engage all involved trading partners, including health plans, your PMS vendor, and any clearinghouse/billing service that your practice uses. In particular, it will be important to determine the ERA capabilities of your PMS software. Taking full advantage of the ERA transaction may require the practice to upgrade its PMS software. Developing a list of pertinent questions to ask all key business partners prior to launching the ERA process in your practice will help ensure success. Use the following document as a guide in developing your list of key points to address with vendors and other trading partners.

Critical Conversations with Trading Partners About Electronic Remittance Advice (ERA)
(PDF, 181 KB)

7   Review Electronic Payment Options and Make an Informed Choice for Your Practice.

Paper checks require your practice to spend time opening envelopes, manually posting payments, endorsing checks, and traveling to the bank. There is also a risk of losing paper checks and higher risk of fraud. Using electronic payment can simplify your practice's revenue cycle and lead to faster payment from health plans. However, you should be aware of the benefits and risks of various electronic payment options so you can make the best choice for your practice.

Automated Clearing House electronic funds transfer (ACH EFT) is now the standard method of EFT used by the health care industry. Similar to direct deposit of employee paychecks, ACH EFT moves funds electronically between the financial institutions of health plans and physicians. Recent regulations require the health plan to include a "trace number" that enables the ERA and the related EFT payment to be reconciled. Practices can maximize the benefits of payment automation by implementing both ERA and the standardized EFT capabilities.

All health plans are required to offer basic ACH EFT upon physician request and at no additional cost beyond a nominal, per-transaction banking fee (approximately $0.34). While health plans or their vendors may offer supplemental "value-added" services for an additional, percentage-based fee, it is important to remember that physicians have the right to request and receive basic ACH EFT at no charge beyond the minimal banking fee. Learn all of your rights related to ACH EFT by downloading this document.

Electronic Payments: Your ACH EFT Rights

(PDF, 65 KB)

Practices must enroll separately with each health plan from which they wish to receive ACH-EFT payments. This plan-by-plan enrollment process can be burdensome for practices. However, federal regulation requires health plans to offer online enrollment, which can ease enrollment hassles. In addition, a number of large commercial health plans participate in the Council for Affordable Quality Healthcare's (CAQH)'s multi-payer ERA/EFT enrollment tool called **EnrollHub**. Rather than having the practice enroll in separate EFT programs with individual health plans, EnrollHub allows the practice to complete the EFT enrollment process once and designate which health plans are to receive the information.

In addition to ACH-EFT payments, health plans frequently utilize virtual credit cards (VCCs) for physician claims payments. Practices are charged interchange fees of up to five percent of their total payment amount to receive these VCC payments. In some cases, health plans are receiving cash-back incentives of up to 1.75 percent from the credit card merchants for using this payment method. In addition to these financial consequences, practices lose many of the automation benefits of standardized EFT and ERA, as VCC payments must be manually posted and reconciled with the remittance advice. Remember, your practice does not have to accept VCC payments if you have requested payments via EFT. Find out more about VCCs with the resource below so you can make an informed decision about electronic payments.

Electronic Payments: Virtual Credit Cards
(PDF, 80 KB)

8   Maximize Collection of Patient Payment.

The growing prevalence of high-deductible health plans means that many patients bear additional financial responsibility for their treatment. In the past, most patients typically had a co-payment due at the time of an appointment; today, many patients owe significantly more for their care due to high deductibles. These trends underscore the importance of your practice's processes of charging for and collecting patient payments at the time of the appointment.

Collecting payments at the time of service—when the patient is still in your office—is the vital first step in any effective patient collections strategy. Doing so will increase your practice's cash flow, decrease accounts receivable, and reduce billing and back-end collection costs. To bill your patients at the time of service, you or your team will need to know the correct amount to charge. Completing an electronic eligibility check before the appointment (see Step 2) will provide information about the patient's financial responsibility for care, including co-payment, co-insurance, and patient-specific remaining deductible. You can then use this information, along with the health plan's current fee schedule, to calculate the amount the patient owes at the time of service. In cases where deductibles and co-insurance cannot easily be determined until the exact services to be provided are known, practices may shift collection activity to the patient check-out process. Be sure to check your health plan contracts for any restrictions on collecting from patients prior to claim adjudication.

Download the following resource for more tips on point-of-care pricing calculations.

How to Calculate the Price of Treatment at the Point of Care (POC)
(PDF, 94 KB)

Effectively communicating information about care costs to patients is also critical to point-of-service collections. Establishing a payment policy and regularly communicating it to patients will manage expectations and prevent surprises regarding time-of-service collections. At a minimum, a payment policy should indicate when patients are expected to pay, how much will be due at the time of service, the accepted payment methods, and what actions the practice will take in the case of patient nonpayment. Because patients often have difficulties understanding their health plan's provisions and the claims payment process, the practice team should be able to provide basic explanations of general health insurance principles to patients and point them to resources if they require additional information. Finally, it's important for your team to be comfortable and effective in requesting and obtaining payment while patients are still in the office. These sample scripts provide tips on how your team members can manage challenging conversations with patients about payment.

Managing Patient Payments: How to Manage and Engage with Patients

(PDF, 82 KB)

While practices should ideally receive most patient payments at the time of service, this is not always possible. In these situations, practices can benefit from a flexible and professional after-service collection strategy. Offering a variety of payment options will enable you to accommodate most patient preferences and maximize your chances of receiving payment. Beyond in-person and mail payments, you may also wish to consider accepting credit card payments over the phone, using patient portals or waiting room kiosks for payment, keeping credit cards on file, and/or offering payment plan options. Please note however that there are many laws governing the extension of consumer credit. If your practice is interested in allowing patients to make payments over time, make sure you contact an experienced attorney to ensure your credit practices meet all applicable regulatory requirements.

A professional communication style will also ensure your team's success with collections. Maintaining a cordial but firm tone during collections discussions—and saying "thank you" after payments are received—will strengthen your practice's relationships with patients.

If a pre-service check finds a patient may have difficulty paying for care, you could categorize as charity care. However, many health plans and federal programs require attempts at collecting what a patient owns to avoid issues of alleged kickbacks to entice patients to come to your practice.

Maximizing Patient Collections After the Time of Service
(PDF, 92 KB)

Collecting past-due patient balances can be challenging and time-consuming for your team. In some cases, employing a collection agency may be the best business decision for your practice. As with any potential business

partner, it is important to thoroughly vet collection agencies before making a selection, as the agency's conduct will reflect directly upon your practice. Download this document for tips to help you select a collection agency.

Managing Patient Payments: Selecting a Collection Agency
(PDF, 137 KB)

Conclusion

Automating and streamlining your practice's revenue cycle can free up time for what matters most to you—patient care. Every workflow that your practice converts from a manual to electronic process will save valuable time and resources and reduce the overall administrative burdens of practicing medicine. For additional resources to help you and your team simplify revenue cycle management, see this module's downloadable tools.

Learning Objectives
1. Describe ways to explain to patients the importance of verifying their insurance eligibility before appointments
2. Explain the benefits of streamlining and automating revenue cycle functions
3. List the benefits of a standardized electronic remittance advice document (ERA) for your practice's efficiencies
4. Identify the benefits and risks of electronic payment options and list steps needed to make an informed decision regarding the best option for your practice

Article Information

References

1. American Medical Association, Medical Group Management Association. Practice Management System Criteria Checklist. 2015.
2. American Medical Association, Medical Group Management Association. Six Steps to Practice Management System Selection. 2015.