Effective Revenue Cycle Management in the New Healthcare Environment

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Revenue is the lifeblood of any business and any significant impact to the revenue of a business could mean many things, including closure. Therefore, revenue cycle management is important, but even more so to medical practices because the source of the revenue can come from so many different people and payors. What is even more of a concern is that the payors have many rules by which a practice and its providers have to comply with in order to receive the remuneration the practice so rightly deserves.

Yet, the healthcare landscape is changing. And through this change, a higher percentage of this revenue is the responsibility of the patient, hence the term, consumer-driven healthcare. Most of us are paying more for healthcare today than we did yesterday, last year and in years prior. Because the landscape is changing, practices can no longer run "business as usual." The policies, systems and tactics previously utilized in the revenue cycle management process will no longer ensure that the funds will show up in your bank account or in your mailbox. Changes in the industry now require changes in billing and collections.

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So what should those changes look like? It does not make sense to review everything we have done because there are bits and pieces of the process that are not broken. But it does make sense to discuss new policies, new thoughts and strategies, along with common sense ideas that will assist you in ensuring those monies arrive where they belong, which is ultimately in the practice's bank account. I will touch on a few points that are very important based on the changing landscape and my experience in evaluating and improving revenue cycle processes in many practices. The first place to start is with the initiation of the patient-physician relationship. This begins when you first speak with the patient to schedule

their appointment, obtain their demographic information, when they arrive at your reception desk or access your website to obtain patient registration paperwork. This is where you first inform the patient of your financial policies and their obligations as a patient in your practice.

This is also the point where the education and training of your staff is imperative to ensure that they obtain all the required demographic information and that the information is accurate, to ensure a smooth process for the patient and the practice. Specifically reviewing each point of contact in your practice where patient information is collected is essential to determine the source of any errors and resolve them once and for all. If there are errors made in the future, in most cases, your billing department will recognize this so there should be a process in place where these errors are tracked, reviewed and communicated to those responsible to correct behaviors as a means of prevention. A little time and effort spent upfront will produce greater efficiency down the road.

Many financial policies are arbitrarily developed or implemented with no real thought on how this will affect cash flow, the staff, or the practice's ability to be efficient. So let's discuss what these policies should look like; but before we do, let me clarify that not all of these policies are going to be right for every provider or practice. You need to decide what stance you want to take and what is going to work for you, your practice and your patients. However, you cannot let your patients dictate how you will run your business. Otherwise, you run the potential risk of eventually not being in business.

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With the increased percentage of revenue becoming the responsibility of the patient, it is now time to seriously consider having a "credit card on file" policy in order to automate charges to credit cards for co-pays and patient balances after claims have been

adjudicated by the insurance carrier. Quality services that are rendered appropriately should not go unpaid, unless the patient has a concern about the services that were received. Having staff or billing companies chase these payments is not efficient or acceptable and can easily be handled inappropriately if the wrong person is responsible for this task. Even clearinghouses and insurance carriers are automating patient payments and collections. Why shouldn't you? Bringing in revenue more efficiently and at a lower cost is what business is all about. It is time to collect the revenue at the time of service or immediately when patient responsibility is applied. So how is this accomplished?

Financial policies first have to be revised to inform the patient that the preferred way of handling payments is to provide a PCI-compliant credit card on file process. This will require the proper merchant services equipment and a financial policy that informs your patients of this

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new policy. A way to sell this new policy is that payments of co-pays and balances due are only charged to the patient's card to a maximum amount per month that they previously approved. This removes any effort on the patient's part to have to "pay bills." And in many circumstances, the patient is informed of the charge via email by the merchant services vendor that keeps the card information on file in a secure manner. For those patients who do not have a credit or debit card or are unwilling to take advantage of this service, the following process is suggested, but it may be tweaked based on your state laws and how the owners of the practice want to deal with the follow-up on unpaid balances.

Once an insurance carrier has paid their portion of the claim and the remaining balance falls to the patient's account, one statement should be sent to the patient to inform them of their responsibility and that payment is expected within thirty days. Patients should be made aware that if payment is not received within thirty days, their account could be sent to collections, at which time, they could incur additional expenses for collection, attorney fees or possible court costs. Management and/or ownership should review each account being considered for collections to determine the appropriate action to be taken. There is no legal requirement or good rationale for sending three statements to a patient if they did not pay after receiving their first statement or call to set up a payment plan. A payment plan option should be communicated on

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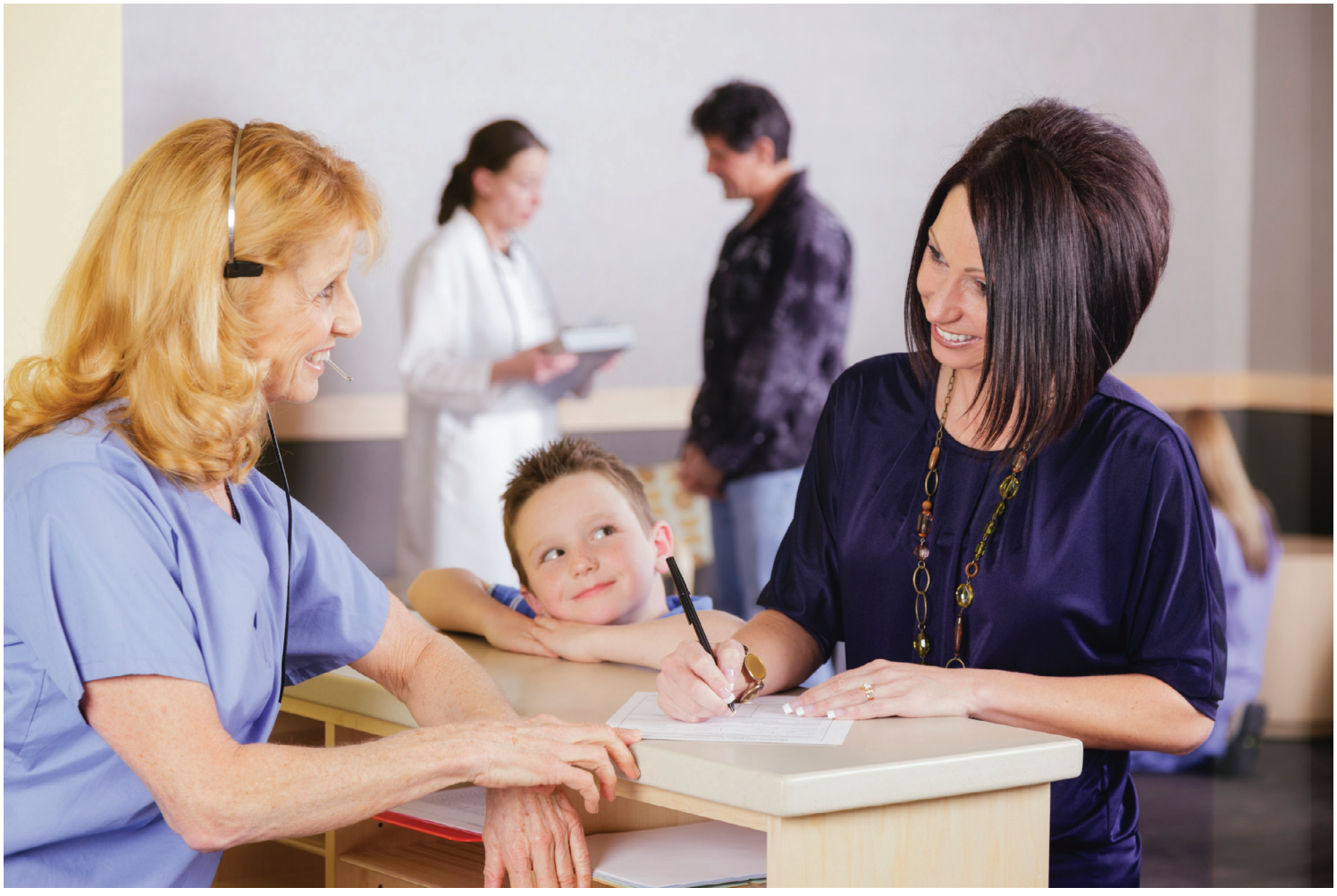

your statements, plus you may want to set a minimum amount that you are willing to accept along with a maximum pay off timeline, based on current state and federal laws. Once an account has been sent to collections, the account should be written off and a note placed in the patient's account regarding the remaining balance should the patient call for another appointment, at which time, payment should be collected prior to scheduling the patient.

Practices should no longer shoulder the responsibility of collection costs given the patient is making the decision on whether their account is sent to collections. Additionally, if the patient is not responsible for this added burden, what else will change the behavior of non-payment for services? This policy has inherently trained the patient that there is no need to take responsibility for their actions because someone else will pay for it.

Care should be taken when considering changes to financial policies because policies, for the most part, should be followed consistently and fairly. Financial policies should not be changed on a regular basis because these should be designed based on the needs of the practice. The policy should be documented and distributed to each patient requiring a signature that they received it. Patients should be reminded of the need to review the financial policy at the time of scheduling their appointment, at the reception desk upon presenting for their appointment, and at checkout. Your policies should be posted on your website and should be reviewed and updated every so often as the needs of the practice change.

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Each of these patient touch points is your opportunity to inform the patient of a more efficient way for them to handle their payments and it is a good time to set up payment plans for patients that currently have account balances. It is also a good time to ensure that the patient was more than satisfied with the care that they received.

Patient satisfaction is a benchmark of continued care by the practice and will most assuredly be a benchmark for payment as the healthcare landscape evolves. By helping to automate the payment of copays or payments on accounts, your staff will have more time to focus on the needs of the patient rather than acting as collection agents on behalf of the practice.

One of the last areas I want to focus on is denied claims. It is, without question, one of the most perplexing issues I find in doing a revenue cycle assessment, in that a payor has basically communicated to you why the claim has been denied. I find more denied claims stuck in drawers, hidden under other paperwork, and just being ignored. In many cases, claims can simply be corrected and resubmitted properly for payment. This is what we call low hanging fruit. Or the payor has communicated a policy that does not allow the service to be submitted. Sometimes the payor is incorrect in their communication and you are therefore required to educate the payor on

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their own medical policies. For whatever the reason, if denied claims are tracked, you can use this metric to your advantage. Place an individual in this position that loves to solve problems and utilize the denied claim metric to evaluate their performance on which claims are able to get paid or which practice policies need to be possibly reviewed and altered to meet the requirements of the payor. This information may also be utilized to gather data to help negotiate your payor contracts.

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The added focus on denied claims can result in fewer denials down the road if this information is reviewed, learned, and policies and procedures are enacted to prevent future denials from payors. Even if you only take one idea from this article and act on it, your practice will be better off and you should see more profits on the bottom line. ■