Revenue cycle management best practices

Improving your practice's financial performance

CGM Insights | White Paper

Claim Denials

"Not only are denials getting larger, but they are also getting harder to resolve."

Jonathan Wiik, Principal of Healthcare Strategy, TransUnion Healthcare

During a practice's revenue cycle, simple mistakes and lost opportunities can hurt your bottom line.

Based on nearly 30 years of experience offering revenue cycle services to providers, we've identified the most impactful, yet easy-to-implement tactics that providers can use to maximize their practice's financial performance.

Any practice can apply these revenue cycle management (RCM) best practices, whether it handles its own billing and collections or uses an outside billing service.

If you are looking for ways to increase revenue, decrease account receivables, reduce expenses, streamline workflow, and most importantly, improve control of your business, find out if your office is following these RCM best practices.

Make it easy for patients to set and keep appointments

A 2021 study from Pew Research shows that internet usage has grown to the point where 85% of U.S. adults say they go online on a daily basis.[2]

In addition to getting news and paying bills online, consumers also want to manage their healthcare online. One of the best ways practices can drive patient engagement, keep schedules full and productive, maintain their customer base, reduce operating costs, and increase revenue is to leverage the power of technology.

Offer a patient portal

Patient portals are a valuable way for health professionals to connect with patients and provide on-demand access to personal health information 24/7/365. Patients can log into their portal account and connect with the medical practice to view information pertaining to recent doctor visits, discharge summaries, medications, immunizations, allergies, lab results and more.

1 Source: Jonathan Wiik. 2020. "Best practice strategies to protect earned revenue through effective denials prevention." Becker's Hospital Review.

2 Source: Andrew Perrin and Sara Atske. 2021. "About three-in-ten U.S. adults say they are 'almost constantly' online." Washington, DC: Pew Research Center.

The Financial Impact of No-Shows

According to Modern Healthcare, as many as 30% of patients fail to show up for their appointment unless proactively reminded.[4]

The cost of all those missed appointments to a practice is substantial. Consumer Health Ratings says that the average patient visit in 2022 is worth between $218 and $311.[5] If your practice has 20 appointments a day, and 30% are no-shows, the impact is $4,360 a week or $226,720 per year—a significant hit to your revenue.

In recent years, patient expectations have changed, too. They want access to a portal that is modern and mobile-friendly. Patients want to schedule appointments and request refills. With a modern portal, you can set business rules, save yourself time, and be aligned with a changing patient market.

According to a report by Zippia, 67% of patients prefer online scheduling. By contrast, only 22% prefer to book by phone.[3]

Online self-scheduling via a patient portal benefits both patients and practices:

- Fill open appointments. Every open appointment slot costs your practice money. So, if you don't fill those spots on your calendar, you're losing money you need to stay in business.
- Increase patient satisfaction. Patients want convenience and accessibility. It takes an average of eight minutes for a patient to schedule an appointment over the phone, and at least 30 percent of that time is spent on hold. For patients with busy work schedules, the ability to schedule appointments online after hours is a significant benefit.
- Reduce administrative burden on staff. With a reduction in call volume due to online scheduling, you can assign your staff to focus on other revenue-generating opportunities for your practice.

Use automated reminders

Surveys indicate that patients prefer an automated appointment reminder to a live call from staff. With the right technology, providers can easily implement appointment reminder automation. Automated messages use patient-specific elements and two-way interaction (confirm/cancel appointment) to maximize response rates from your patients.

Providers can deliver automated phone, email, and text appointment reminders. Texting is critical as a wider age range of patients are using smartphones than ever before. Benefits for practices include:

- Decrease in reminder expenses. Eliminate postage expenses for mailed reminders and eliminate the expense and inefficiency of staff members manually calling each patient to confirm appointments. Automated appointment confirmations are delivered more quickly and for a fraction of the cost.
- Ability to receive advance notice of cancellations. Giving patients the option to cancel through an automated message prevents a potential hole in the schedule and allows you to fill that opening with another patient who needs to be seen.
- Reduction in no-shows. Appointment reminder notifications have been proven to lower no-show rates by up to 25%. This reduction helps providers retain planned appointment revenue.
- Additionally, practices can leverage on-demand messaging to help drive additional revenue opportunities or inform patients about upcoming office events or closures.

Always check eligibility and switch to electronic eligibility verification

Verifying patient eligibility is an indispensable process when it comes to billing patients, getting paid by insurance providers, and managing a practice's revenue cycle. With the rise in high-deductible and cost-sharing insurance plans, more and more patients are required to make payments at the time of service. By using eligibility verification—particularly when done in advance—practices

3 Source: Caitlin Mazur. 2022. "23 Appointment Scheduling Statistics [2022]: Online Booking Trends." San Francisco, CA: Zippia.

4 Source: Adam Rubenfire. 2021. "The key to reducing no-shows: Empower your patients." Modern Healthcare.

5 Source: 2022. "Doctors' Charges, Physician Prices, Average Cost, Anesthesia." Consumer Health Ratings.

can communicate important information to patients about the costs of their appointments before they arrive.

Best times to verify patient eligibility:

- Time of booking
- Prior to the appointment
- When the patient arrives during check-in

After you verify eligibility, use the information provided by the patient's insurance provider, as well as your practice's contracted rates, to calculate a price estimate for your patients.

Compared to a manual process, electronic eligibility verification offers two significant benefits:

- Cost savings: The medical industry saves $8.64 for each eligibility and benefit verification converted a manual process to an automated one.[6]
- Time savings: The average provider spends approximately 21 minutes manually verifying a single patient's insurance eligibility.[7] Manually checking eligibility for 25 patients in a day would consume 8.75 hours—a full day's work for one of your employees.

Make patient responsibility transparent and engage your patients

According to Becker's Healthcare, the average physician practice writes off more than $30,000 in unpaid medical bills each year. The following are three effective ways practices can proactively encourage patients to pay their bills in a timely matter:

- Collect payment from patient at check-in/check-out. The best time to collect patient balances is during the check-in or check-out process. Make sure you are offering multiple payment options and that you have the right technology and tools, such as card and check scanners, to easily accept payments.

6 Source: 2021. "2020 CAQH Index." Washington, DC: Council for Affordable Quality Healthcare.

7 Source: 2022. "2021 CAQH Index." Washington, DC: Council for Affordable Quality Healthcare.

ARIA

RCM Services

About ARIA RCM Services

In addition to helping providers with credentialing and enrollment, our ARIA division specializes in revenue cycle management.

When you outsource all or part of your billing operation to ARIA RCM Services, our experts fight to recover the thousands of dollars every month you may be losing in denied claims, underpayments, missed deadlines, and inaccurate coding.

ARIA has a proven track record built on years of experience working with healthcare organizations of all sizes.

ARIA RCM Services believes in full transparency, operating as a member of your team and providing detailed reporting that keeps you in control of your business.

- Communicate clearly and consistently with patients about payment. Post signage and develop scripts that help your staff ask for payment during patient check-in. Starting from the time the appointment is scheduled, your patient should be informed that payment is expected at time of service.
- For post-visit bills, consider switching to electronic statements. Consumers are accustomed to paying online. Practices can increase their chances of collecting by using e-statements, e-pay, and text-to-pay options.

Monitor your claims and denials

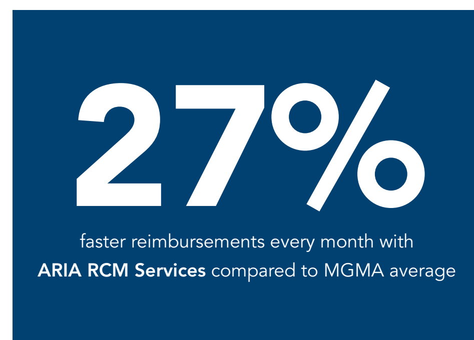
Nothing throws a wrench in your revenue cycle quite like a growing list of denials. For your practice, denials mean less money in the door, more work for your staff, and less consistency in your monthly AR. In fact, it is estimated that it costs as much as $118 in administrative costs to rework a denied claim.[8] Even if you think it was less in your practice, how much would you willingly give away? $75? $50? Fortunately, the five most frequent causes for claim denials[9] are surprisingly easy to correct:

Duplicates

The largest percentage of claims denials come from duplicates. More specifically, they are the result of practices resubmitting claims before having received the initial response back from their insurance payers. To minimize these occurrences, make sure to keep a firm handle on your claims inventory. Many practice management systems allow users to note activity on claims. Instruct your staff to leverage these features so that everybody in the practice can see what actions others have taken. It is also important to work your claims on a regular schedule and keep your rejection queues as organized as possible.

Incomplete claims

Denials due to human error take almost twice the amount of work to correct and resubmit. Understanding your practice's most commonly made mistakes will help you identify and prevent these sorts of errors moving forward. Your clearinghouse should provide you with rejections reports for precisely this purpose. Add a front-end claim scrubbing tool and, as simple as it sounds, rigorously schedule time to keep up with rejections.



Expired eligibility

Make sure you are taking advantage of an electronic eligibility tool through your clearinghouse and are performing eligibility checks on your patients when they arrive for their appointments, in addition to any checking you do when they schedule. A surprising number of eligibility expirations occur in the time between the phone call to schedule the appointment and actual check-in. To ensure all staff is aware of a patient's eligibility status, make sure you notate the information relevant to your practice in your practice management system.

Claims not covered by insurer

Eligibility verification helps providers identify instances of claims not being covered by the insurer. Practices that use a real-time eligibility tool will be able to recognize these situations beforehand so that providers can discuss options with patients prior

8 Source: Kelly Gooch. 2017. "Denial rework costs providers roughly $118 per claim: 4 takeaways." Becker's Hospital Review.

9 Source: Kevin Fuller. 2013. "Top 5 medical claim denials." Healthcare Finance.

to service. When high-dollar procedures are involved, make sure you follow up with insurance carriers via phone if your electronic eligibility response does not provide you with the specifics you need.

Clean Claims Rate

One important KPI for your practice is your clean claims rate.

A clean claim is one that is immediately reimbursable and does not require manual intervention.

A healthy clean claims rate suggests that the data collected and processed through the EHR are accurate and complete. Alternatively, some practices rely on a claim processing tool to make up for shortcomings within their EHR.

Timely filing issues

Timely filing issues are addressed best through workflow and organization. Keep to your claims submission schedule, prioritize your high dollar claims first, and work your rejections promptly and in an organized fashion. By incorporating the tools discussed with the rest of these denial reasons, you can also minimize the chances claims are delayed at the clearinghouse level due to errors.

Manage your payor contracts

According to the Medical Group Management Association, as many 7% to 11% of claims are underpaid relative to the terms of payer contracts.[10] This can add up to significant revenue loss for your practice.

As an example, a practice bills "Payor A" $100,000 per month for services rendered. However, "Payor A" consistently underpays the practice's contract by 10% or $10,000 each month on the practice's top CPTs. This means the practice is losing upwards of $120,000 per year in underpayments.

Identifying underpayments and then adjudicating them with each of your payors can be a daunting process for practices to tackle alone. Underpayments are spread across hundreds of patient records, which means the amount per patient is small and easily overlooked.

Monitoring and appealing expected payments doesn't have to be overly complicated or expensive—if you have the right resource or partner working on your behalf. The right system will allow your practice to create a system knowledge repository on fee schedules and reimbursement rules for your key payors, create system flags and alerts to identify underpayments for every line item, and create

10 Source: Eric Matson. 2021. "Ensuring the revenue cycle gets a clean bill of health." Healthcare Financial Management Association.

individual appeals with a given payor to set precedent, followed with bulk appeals if necessary.

Establish key performance indicators (KPIs) for your practice

Many practice management systems offer a number of in-depth financial reports. Use the key performance indicator data from these reports to help you identify potential problem areas so that you can develop plans to improve.

- Understand your Accounts Receivables (AR)

  Your AR represents how quickly your practice is paid for the services it provides. Look at your AR balances for all payers as well as your outstanding patient balances, and see how these trend month-over-month. An upward trending patient AR balance could speak to the need to improve patient collections efforts. Additionally, pay attention to your AR Aging. Older AR is harder to collect, and a rising trend in 90+ day old AR indicates problems in your practice's collections efforts. The MGMA recommends that 90+ day old AR should be less than 14% of your total.

- Run a CPT analysis.

  Prior to the end of the year, run a utilization and payment analysis by CPT to help you understand how any contract changes with your payers will affect your reimbursement for the next year. Determine which codes your physicians bill the most and which they bill the least. Identify which CPTs are high-margin. Small changes to commonly-used codes can have a big impact.

- Analyze your payers.

  Where are you being underpaid according to your contracts? Are you being overpaid anywhere? What are your most common adjustment codes? What are your most common reason codes for denials? Understanding this information can help you better educate your staff on individual payer requirements when billing claims and minimize denials and rejections.

For your most frequently used key performance indicators, the most important question to ask is: how has this changed since last month? The earlier you can spot negative trends, the easier it will be to course correct.

Bonus tip: Ensure your billing lifecycle is set up for maximum revenue collection with an RCM partnership

Working with an outside billing services company can help you remove administrative burdens from your team, while improving your practice's financial performance. The benefits of leveraging the staff and experience of an outsourced revenue cycle management services provider include:

- Navigating the entire revenue lifecycle with the help of an expert that understands payer billing rules, audits, recoupments, appeals and denials
- Ensuring your billing lifecycle is set up for maximum revenue collection

11%

of claims may be underpaid relative to the terms of payer contracts[10]

Contact ARIA RCM Services

ARIA RCM Services offers comprehensive revenue cycle management services from claims generation, to payment posting, to insurance collections for independent physician practices, hospital-based groups, facilities and health plans.

To learn more about ARIA RCM Services, fill out this brief **contact us** form.

About CompuGroup Medical

CompuGroup Medical is one of the leading e-health companies in the world. Its software products are designed to support all medical and organizational activities in doctors' offices, pharmacies, laboratories, hospitals and social welfare institutions. Its information services for all parties involved in the healthcare system and its web-based personal health records contribute towards safer and more efficient healthcare.

CompuGroup Medical's services are based on a unique customer base of more than 1.6 million users, including doctors, dentists, pharmacists and other healthcare professionals in inpatient and outpatient facilities. With locations in 19 countries and products in 56 countries worldwide, CompuGroup Medical is the e-health company with one of the highest coverages among healthcare professionals. More than 8,500 highly qualified employees support customers with innovative solutions for the steadily growing demands of the healthcare system.

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