Provider Revenue Cycle Management (RCM) and Proposed Solutions

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Executive Summary

It takes more than world-class service to be competitive in the health care industry today. With reimbursements decreasing and cost of healthcare services increasing, hospitals are struggling to keep afloat. Today’s business office is no longer a cost center, but is viewed as a revenue maximizing department. Healthcare organizations are under pressure to cut costs, improve reimbursement and cash flow while improving efficiency in an era where resources are scarce.

The Provider Revenue Cycle and its appropriate management is the crux of profit maximization. By the same token, it remains a process that has room for optimization through the use of technology and process reengineering.

The following white paper attempts to introduce the reader to the basic concepts of Provider / Hospital RCM, the pain areas and possible solutions to address these.
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Introduction

What Is Cash Flow For A Provider / Hospital?

Cash Flow is the ability of the hospital to collect its receivables in the fastest, most accurate method possible. Many methods of collection are used:

- Time of service collections
- Data mailers
- Phone calls
- Collection letters
- Automated balance inquiry via phone
- Predictive dialing for small balance accounts
- Small claims court
- Collection agencies or early out

What is Revenue Cycle Management (RCM)?

RCM is a process by which services are provided, charts coded, charges billed/submitted and cash generated. Revenue cycle is the term used to cover a large spectrum of functions to procure cash flow for hospitals and health systems.

Revenue Cycle activities include:

- Scheduling / Appointments
- Verification Check (referral, authorization and pre-certification management)
- Pre-registration
- Registration
- Time of Service Payments
- Coding
- Demographics and Billing data entry
- Patient Statements
- Collections and payment posting
- Denials and appeals
- Account follow up
- Financial counseling

Central Business Office (CBO) is the department within the hospital that strives to maximize cash recoveries. A CBO is always involved in all or some stages of the revenue cycle as will be explained in some details under the models of RCM.

A/R Management: Accounts Receivable (AR or A/R) Management is a key, but not the only component of effective RCM. GDRO (Gross Days Receivables Outstanding) is commonly used as a measurement of the effectiveness of AR Management. Accounts
Managers cannot afford a high GDRO since this represents cash that the hospital could otherwise be using to pay bills.

From the above Revenue Cycle activities, the following would fit broadly fit into AR Management:

- Collections and payment posting
- Denials and appeals
- Account follow up

The Revenue Cycle

The patient revenue cycle comprises all of the administrative functions that contribute to patient access, creation of patient charges, submission of bills and cash collection.

Scheduling / Appointment Management and pre-registration / registration

- Schedule OP / IP visits and procedures
- Gather demographic information
- Obtain insurance information

Gathering demographic and insurance information prior to actual registration is pre-registration. This allows for more accurate and timely collection of information as patients and staff may be pressed for time and information during the time of registration.

Verification

- Obtain insurance authorization, if required
- Pre-certification: Review of "need" for inpatient care or other care before admission (by the MCO)
- Obtain referral information: Is the referral authorized by the PCP? Is the PCP referred service covered by the plan?

**Payment collections at the time of registration**

- Co pays
- Self pays

**Charge Capture (Coding)**

- Identify activities and charges for an encounter
- Apply CPT and ICD 9 codes
- CPT: Current Procedural Terminology: Used to capture codes for medical or psychiatric procedures performed by physicians and other healthcare providers.
- ICD-9: International Classification of Diseases (9th revision): Used to capture codes for disease diagnosis and surgical procedures

**Billing**

- Enter charges
- Adjust capitated charges

**Patient Statements**

- Submit primary claims
- Submit secondary claims
- Produce patient statements
- A patient statement would typically contain the following information:
  - Time of service collections
  - Outstanding patient balances collected at the time of service.
  - Charged amount for current service with appropriate codes
  - Insurance details
  - Electronic vs. manual submission of claims
  - Forms used (UB 92/04 and HCFA 1500)

**Collections and payment posting**

- Post all payments and adjustments
- Deposit money into bank

**Denials and Appeals**

- Resubmission/Appeal of claims
- Denials Analysis
Bad Debts and Write offs

Account follow up

- Handle patient inquiries
- Resubmit claims
- Issue refunds

Revenue Cycle Models

There are 4 revenue cycle models that can be considered:

1. **Centralized**: In this model there is centralized control of all the revenue cycle functions. In a slight variation to this, an organization may choose to separate out charge capture, coding and data entry and this responsibility will be handled by the respective departments.

2. **Decentralized**: In this model, only key functions are retained centrally (like IT, claims submission, customer service and compliance)

3. **Outsource**: In this model, certain back end functions may be outsourced to an external firm.

4. **Menu**: In this model, there is a range of billing options, from outsourcing components of the billing process to utilizing the CBO to conducting components of the process within the departments.

The most successful model for an organization always depends on the specific organization’s needs and there is no one perfect model.

RCM Performance Measures

- **Aged A/R Per Month**: This is an aged trial balance that separates the A/R by “aging buckets,” (i.e., 0-30 days, 30-60 days, etc.). It should be the organization's aim to maximize the first bucket and minimize anything above 60 days.

- **Gross and Net Collection Rates** (by month): This is the money collected based on the charge for the service or the collectible revenue respectively. This is dependant on the payor mix and charge structure and is generally meaningful for a trend analysis. Net collection rates should always be towards 100%.

- **Total A/R and Days in A/R**: This is the number of days required to collect the charges submitted to payors. This is again dependant on the charge structures, presence of electronic submission, etc. However, above 90 days definitely indicates a need for improvement.

  - Monthly Charges, Payments (receipts), and Adjustments reports

Benchmarks for performance may be set by an organization using internal or external sources like historical performance, budgets, industry reports etc.
Factors that affect performance:

- Organizational Structure
- Accounting practices
- Payor mix
- Contracting effectiveness / negotiating leverage
- Information system capabilities
- Specialty mix
- Interpretation of surveys

However, in order to get a clearer picture of the entire revenue cycle (RC), key functional areas should be reviewed for performance in more detail like Scheduling, Coding, Charge Capture, Time of Service Payments and Referrals / authorization procurement. Targets and best practices can be put into place to measure the performance of these functional areas.

Outcomes related to effective RCM include:

- Improved collections
- Enhanced cash flow
- Greater customer service
- Efficient and effective ambulatory operations

Overview of the Problems in the RCM Process

Some of the significant challenges faced by most experienced organizations are:

- Increasingly complex billing requirements
- Delayed managed care payments
- Decreasing reimbursement levels
- Outstanding debt

Also any combination of the following factors will hurt profitability:

- An increase in AR days
- A surge in the number of denied claims
- A decrease in cash collections
- Increases in customer service complaints
- Bad debt expense
- Staffing costs resulting from reworking claims and spending on collection agencies
Further, provider margins are usually razor thin (< 2%) to non-existent, in part because capitated contracts leave no room for profits, government payments barely cover variable costs, and non-funded government mandates take resources away from patient care. Thus, PPO and Fee-For-Service like arrangements, which make up approximately 35% of a provider's revenue base, are becoming the only profitable payors.

To elaborate on the problems faced, an example could be the central business office (CBO), where there is a tremendous pressure to generate accurate billings in a timely fashion and to reduce the days in accounts receivable. Limiting factors to achieving this goal are the accuracy and access to proper patient, insurance, and billing information. Making the task of A/R reduction even more complicated is the fact that information is maintained in a separate electronic and paper folder each time the patient receives services for clinical care.

Delays, mistakes, misunderstandings, and misplaced information each jeopardize healthcare organizations' cash flow and revenues. As surveys are showing, hospitals don't collect between 4% and 12% of the money they are entitled to. Additionally, complicated billing and collection processes delay the average payment for services rendered by 75 days, compared to only 28 days for non-healthcare organizations. The typical turn around time for a medical insurance claim is 90 days according to the health care financing administration. A typical claims filing (when filing claims on paper) has a rejection rate of 30%. Duplicate claim payments and payments for ineligible members can easily reach these amounts even for medium sized health plans. Overpayment rates of 1% to 2% of medical expenses are common and for a small health plan or a self insured employer, can be over $250,000 a year.

Healthcare providers need a system that can help them reliably increase their percentage of first time "clean claims". However, health plans will continue to delay payments because of improper Authorizations (45%) while they increase the requirements for more clinical documents in the form of attachments. Payors increasingly complicate the requirements for a “clean claim” making it more difficult for providers in maintaining effective cash flows.

_The problems faced in each of the Revenue Cycle activities are enumerated below:_

**Scheduling / Appointment Management and pre-registration / registration**

This process begins at the point where an appointment / investigation / procedure is scheduled up to the point of admission (if required). As a patient advances through scheduling and pre admission, the ability to collect both information and cash is greatly reduced which lowers the revenue generation process.
In scheduling and pre-registration, many a time the staff is not well-trained and equipped to handle this process comprehensively. Some key activities which need to be carried out at this stage are:

- Collecting correct patient demographic/insurance/clinical information
- Ability of a real time check with the Payor system for verification of insurance information
- Advising patients of their financial obligations
- Informing them in advance of what documents they should bring.

Faulty processes increase the time the staff spends on reworking accounts as well as subsequently increase the amount of delayed and denied claims. Some of these processes are:

- Staff captures inaccurate or incomplete information due to which the claims cannot be forwarded to the third party payors
- Staff captures inaccurate or incomplete information due to which the claims are rejected. Eg: Patient’s insurance may require a co-payment or when a patient has an outstanding balance as part of the registration process
- Patients may enter the system through other avenues outside the traditional central admitting, such as OP clinics, emergency room etc. Lack of proper communication and processes, leads to errors and problems as described in the above two points.

**Verification**

The following are some of the problems encountered during verification:

- Not obtaining/verifying accurate insurance name, number and eligibility
- Not securing pre-certification, and pre-authorization with time limits for certain procedures
- Not making copies of the insurance card
- Not checking for secondary coverage
- Missing/expired referral/authorization number
- Lack of a referral tracking process
- Inadequate staff training

**Charge capture (coding)**

Coding is a central and key component in the entire reimbursement process. It greatly helps in each claim being “audited” internally before being submitted thereby reducing the percentage of rejected or down-coded claims.
More than 80% of hospital cases are coded in error (usually under coded) and out of compliance with today’s mandated federal coding standards. In patient/Out patient coding errors cause denials or returned claims. Charge entry should be performed at the front end at the time of service. This eliminates the opportunity for a lag between the date of service and the charge entry. Studies have shown that the average charge lags were 19 days for inpatient and 15 days for outpatient.

Lack of a comprehensive mechanism for determining and adjudicating duplicate claims leads to excess payment. Duplicate claims find their way into the system and get paid due to two main reasons: in-adequate reporting and errors in data entry.

**Payment collections at time of registration:**

Some of the problems faced during payment collections can be reduced by adopting the following measures at the time of registration:

- Communicating the policy to patients
- Holding clinic staff accountable for collection
- Performing co-payment/outstanding balance collection on the front end at the time of service
- Developing reconciliation procedures for co-payments/outstanding balances collected

**Denials and appeals:**

Denials represent the state of the highest financial exposure since all costs have been incurred and payment is still outstanding. By incurring all delivery costs and receiving a complete denial or only partial payment in response to the claim, the provider has 2 options: appeal or write off. Both result in net revenues that are lower than would be predicted during the early patient access stages of the cycle. It usually costs a provider $14 each to handle an appeal. The gateway to reducing denial rates and appeals is by:

- Understanding of reimbursement contracts
- Understanding payor procedures
- Denial Analysis
Proposed Solutions

Succeeding as a health care provider increasingly hinges on maximizing efficiency in access care through billing, collections, reimbursements, and an array of related business functions that are critical to preserving revenue and achieving top cash flow potential.

In the previous section, we discussed about the problems in each of the revenue cycle activities. Here, we are going to talk on some of the proposed solutions of Wipro for RCM.

Process Reengineering Study:

RCM is concentrated on utilization management and revolves around documentation, bill presentation and correction. Delays, mistakes, misunderstandings, and misplaced information each jeopardize healthcare organization’s cash flow and revenue.

Wipro can help in doing a complete Process Reengineering Study comprising of 3 phases—analysis, design and implementation. The analysis phase will be a comprehensive review/assessment of the current revenue cycle policies, procedures, staffing, technology usage and workflow. Knowledge of the entire processes will help in the design of efficient and effective processes to assist in efficient generation of revenue. At the end of the study a recommendation and implementation plan will be chalked out for procedural, operations, technology and financial improvements.

Strategies to understand and prevent denial management:

A thorough understanding and management of reimbursement contracts, payor procedures and claim denials is necessary for being able to predict a successful revenue collection. We can help in the evaluation and selection of the most appropriate and latest (technology) denial management application. This will allow the provider to adapt to payor denial strategies in increasingly shorter time frames and will be able to evaluate their performance using powerful predicted revenue collection metrics, which will ultimately result in decreasing denial rates and being able to proactively challenge payment denials.

Outsourcing:

Organizations should conduct a thorough review of current processes while also eliminating a backlog of accounts. We can help the hospitals in doing a study and
evaluating which of their functions in this area can be outsourced. For example, hospitals can consider outsourcing the backlog of collections to help improve cash recoveries and free up staff time.

**Web Technologies:**

Help in automating workflow processes, approval by implementing these technologies especially to facilitate appointments, schedules and the complete pre-registration process.

**System Integration:**

This would involve integrating the front end, the clinical and the support processes to work in tandem to ensure error free transactions. Integration of disparate billing systems will lead to better contract management and negotiations for the provider.

**Billing Technology Point Solutions:**

Technology can play a critical role in enhancing the efficiency of the RCM as described earlier. We can also provide the following point solutions to the providers to support the billing processes.

- **Flexible front end charge editing systems** that ensure accurate and effective coding and charge entry prior to claim submission. Utilize available code editing technology to enhance the efficiency of the coding process and to enable correct determination of ICD-9 and CPT codes.
- **Billing system modules** that automate the identification, tracking and reporting required in procuring and processing referrals/authorizations.
- **Online eligibility verification systems** with payors via the internet or other electronic file transmission processes.
- **Effective Reporting package:** As mentioned in the RCM performance measures earlier, the 5 performance measure reports represent a complete overview of the patient accounting department trends. These reports provide an excellent opportunity to foresee potential problems related to cash flow and take preemptive action. For example: If the days in A/R indicates a general trend in rising days, the detailed analysis of the data may point out that one specific payor is responsible for the increase.
- **Claims have to be sent out in a standard format according to HIPAA.** In case the provider is not using a clearinghouse we can convert existing formats into standard formats by either implementing a translator tool, building our own or writing wrappers.
- **Conversion of paper to electronic submission.** We can provide services for this according to existing standards.
Benefits & Conclusion

Healthcare organizations that have implemented RCM have seen a 28% decrease in the average days in Accounts Receivable (A/R) and an increase in the average collection rate per case mix adjusted patient day of 4.8%.

The proper implementation of RCM technology can improve the timely access and tracking of billing and collection information within the business office.

This in turn will lead to greater profits, smoother processes and ultimately increased patient satisfaction.