How To
Improve Your Medical Practice Bottom Line:

Medical Billing, Key Performance Indicators, and More

By Owen Dahl

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About the Author

Owen Dahl is a nationally recognized medical practice management consultant with over 43 years experience in consulting and managing medical practices. Expertise includes: revenue cycle management, strategic planning, mergers and acquisitions, organizational behavior and information systems implementation.

A published author, Mr. Dahl has written titles including *Think Business - Medical Practice Quality*, *Efficiency, and Profits*; *The Medical Practice Disaster Guide Book*; and co-author of *Lean Six Sigma for the Medical Practice – Iimproving Profitability by Iimproving Processes*. In addition he writes and contributes to articles in *MGMA Connexion*, *Medical Economics*, *Physicians Practice* and several others.

Mr. Dahl received his Bachelors degree in Hospital Administration from Concordia College, Moorhead, MN; his Master's from the University of Northern Colorado, and has done doctoral work at NOVA Southeastern University, Ft. Lauderdale, FL.

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> **"My reimbursements continue to go down, I'm working harder than ever, my staff is working very hard and yet they can't keep up with all the rule changes and complexity in the billing of a single claim!"**

> **"We are all frustrated, everyone wants to quit but they can't!!!"**

These comments are taken from real practice administrators who are frustrated as well. **More uninsured, more underinsured,** more patients with **high deductible plans** and who know what the advent of the "Health Exchanges" will mean in 2014.

How to Improve Your Medical Practice Bottom Line: Medical Billing, Key Performance Indicators, and More

The challenges facing medical practices are numerous:

- It is not necessary to dwell on the concept that **reimbursement levels are decreasing**. The Medicare sustainable growth rate (SGR) annual scare is enough to make everyone stop and realize that sooner or later this will have an impact on the bottom line of your practice. The battles have been won to date, but it is unclear how many more are on the horizon, and what those outcomes will be. Managed care companies watch the SGR battle closely in addition to their own efforts to reduce per-procedure reimbursement.

- The medical practice is facing **more regulations than ever before**. Coding requirements are stricter and payer demands for authorizations prior to providing the treatment are greater in number. And, there is no guarantee that payment will be received.

- Even with the unemployment rate as high as it is, **skilled, willing workers with revenue cycle management experience and knowledge are difficult to find**.

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The challenges facing medical practices are numerous:

- **Technology is complex** with 837 electronic claims submissions and 835 electronic remittance advice formats. Practice management software provides "canned" reports that do not truly provide the information necessary for medical practices to utilize it effectively. Options can be purchased from software companies or outside vendors that will make the processes more automated, but why should medical practices have to spend additional money to make the product functional?

- **Recovery Audit Commission (RAC) audits are also on the horizon for medical practices**. The Federal Government believes that medical practices have fraudulently bllled, or at the very least, perpetuated abusive billing. RAC findings affect not only refunds, but civil or criminal penalties could be leveled against the medical practice as well.

- **The medical practice must have a compliance plan in place** which addresses the approach to internally controlling any fraudulent or abusive billing practices. This means coding audits and potentially independent reviews of the documentation and coding decisions made by the providers.

The question then becomes, *how do medical practices work to manage these issues cost-effectively with results that insure that the doors remain open for business?*

Let's start with a review of how the revenue cycle should work in any medical practice…

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Approximate % of Work Effort to Manage RC (by Key Areas)

27%   FRONT DESK

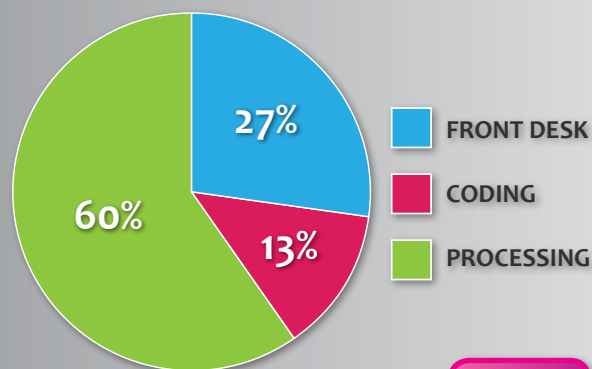13%   CODING

60%   PROCESSING

Figure 1

The Revenue Cycle

The Revenue Cycle (RC) consists of three major areas of emphasis. This work load is like an assembly line. The front desk must complete its tasks of account set up before the encounter form can be generated by the clinical staff, which all needs to be completed prior to the insurance claim being submitted. Even though each step is necessary, the volume of work involved in the RC is heavier on the processing side than any other, and all parts must work together. In **Figure 1** left, please note the approximate percentage of work effort required to manage the RC by the key areas. The chart is an estimate of the "normal" relationship between these major areas. There is no real scale that indicates which is more important: all are absolutely necessary.

In order to meet the demands of proper management of the RC, it is necessary to address it as a complete process and not to look at just one part. Too often fixes are a result of a quick look at one part of the RC, and changes are made that realistically won't solve the problem. In fact, greater issues often surface in this scenario. For example a denial report states that patient demographics are the reason for most of the denials. Although it looks like the problem lies with the receptionist, in reality, there may be many issues that caused the denials. Staff training, lack of delineation of tasks and proper staffing at the front desk could all have contributed to the number of denials. But the issue would not have surfaced if there was not a report from the processing section indicating that there were errors in that area. All component parts of the RC must work together.

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The Revenue Cycle

To gain better insight into the symbiotic nature of the process, review **Figure 2** below, which is a simple flow chart of the revenue cycle.
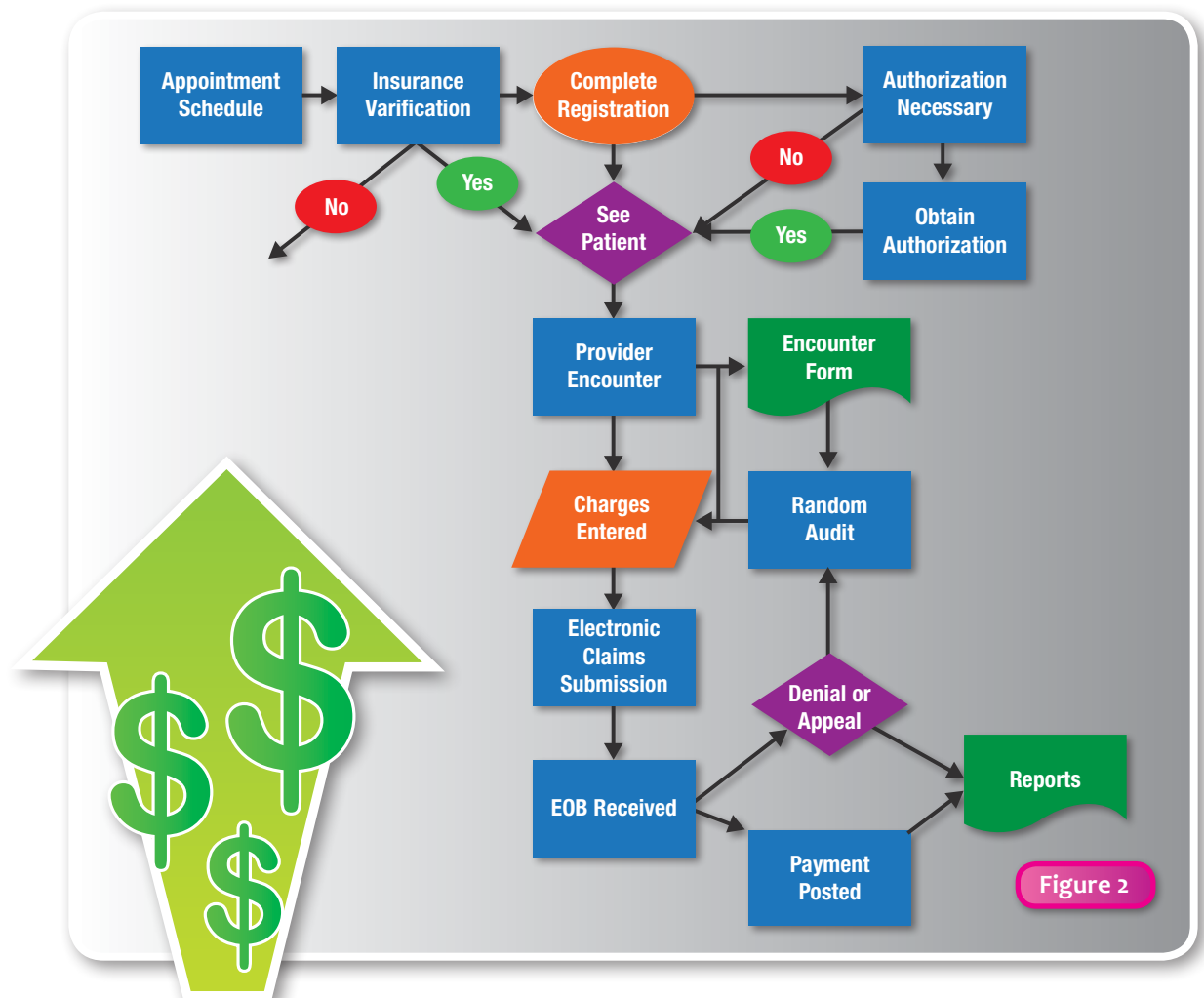

Figure 2

Image courtesy of photostock / FreeDigitalPhotos.net.

Basic Duties of the Three Sections of RC

1

Front Desk
- Patient scheduling
- Patient demographics
- Insurance information
- Verify insurance coverage
- Collection of co-pay, deductible and previous balances
- Obtain authorization for services if necessary

2

Coding
- Complete encounter form
- Identify level of service, diagnostic and/or treatments performed with description or CPT code and diagnosis code
- Charge entry through connected electronic health record

3

Processing
- Charge entry from completed (encounter form if charge form not done by the physician or clinic staff)
- Code review
- Submit claims through clearinghouse
- Review unclean claims, repair and resubmit
- Receive explanation of benefits (EOB) and funds
- Process payment
- Identify denial and appeal needs from the EOB
- Appeal claims as necessary
- Re-file claims for underpayment
- Process patient statements
- Update patient account on status of payment
- Process patient account to final disposition, e.g., payments complete, write off or turn to outside agency for assistance

▶ **Thus, we can see the complexity and potential for errors throughout the process. The "assembly line" must work like a well-oiled machine to eliminate errors and to achieve the desired bottom line.**

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Policies for Managing Your Revenue Cycle

In order to have a successful RC, it is necessary to develop two separate sets of policies. The first is a financial policy (FP) which informs the patient about the expectations for them (as noted in the following paragraph). The second policy is a collections policy (CP) which provides guidelines related to the entire RC process. Policies themselves are no good without an educational effort for new and current individuals involved. Notice the word individuals; it is necessary to educate not only the employees involved but the patients as well.

FINANCIAL POLICY

Step one in establishing your Financial Policy is gaining a clear understanding of the terms of your managed care contracts (HMO and PPO), since certain contracts dictate how and what can be done with regard to amounts and approaches to collecting balances from patients. A contract will spell out the responsibility that the practice has to collect any co-payments and/or deductibles. Typically, the statement is clear: the patient has the responsibility to meet their co-payment, deductible or co-insurance payment at the time of service. The requirement should be noted on the FP as well as displayed at the front desk.

The FP should inform the patient that the practice will process their insurance as a courtesy to relieve them of the burden. This includes primary and any other additional insurance forms that the patient may have in effect at the time of service. Therefore, it is essential that the patient inform the practice when there is a change in their insurance coverage or carrier. Staff should ask the patient to see their insurance card with each visit and verify address and phone number as well.

The FP should also inform the patient of the way statements are handled. When balances become due after the insurance claim has been processed, the patient will receive a statement which indicates the remaining balance due. It is now the patient's responsibility to pay that balance in full immediately upon receipt of the statement.

Unfortunately, there will be times when the patient will choose not to respond to the statements. Since this is a possibility, the FP should include a notice that if there are additional costs associated with collecting any unpaid balance, it will be the patient's responsibility to assume those costs. These may include any interest, processing or outside agency costs which will be applied to the balance due.

The practice should also review its no-show or cancellation notice policy. If the decision is made to charge the patients for a no-show, the FP statement "warns" them of this cost and that the practice expects payment.

This policy should be in writing and given to each new patient or existing patient when it is revised. The patient should sign and retain a copy, and the practice should retain a copy or scan the original into the patient's record. The policy may also be posted on the practice web site so it is available as a ready reference, and potential patients may review it prior to making an appointment. It is better to have a clear understanding of these expectations prior to, or at the time of, establishing the patient/physician relationship.

Policies for Managing Your Revenue Cycle
(Continued)

COLLECTION POLICY

The first step in improving your RC is to insure that everyone clearly understands the financial policy and how to effectively communicate it to the patients. Each employee, even those on the "clinic" side, should be educated on the process and what is expected. Each employee is thus expected to support the policy and refer to it when patients ask questions.

The front desk staff is the first point of contact. When a new patient appointment is made, the scheduler should be prepared to obtain pertinent information such as name, address, date of birth, and, if willing, their social security number. In addition, the patient's primary insurance carrier and any co-insurance information should be obtained along with any identification numbers. Once the appointment time is established, the patient should be set in the queue for verification.

Very often there is not a clear understanding of how the physicians expect collections to be handled. One physician may not wish to pursue any outstanding balance after insurance and a reasonable effort has been made to collect, while another physician may want every effort put forth, including turning the account over to a collection agency or even to an attorney. Without a clear agreement from all the physicians, the staff is then caught in the middle in their efforts to collect. Patients also talk, and when one is turned over to a collection agency and another one is not, word gets out in the community about who to see, or that the practice doesn't follow the same guidelines for all their patients. Therefore, it is essential that the physicians be proactive and agree to create a CP that is clearly defined and understood by all employees.

There is a built in conflict when considering how aggressive the collection policy should be. An overriding principle is the primary goal, which is to maintain a positive relationship with the patient. This means that there should be a balance between how aggressive the collection effort should be. Upsetting the patient with harsh tones and terms is not effective in collections or in maintaining the relationship. On the other hand, the medical practice is a business that provides services to the patients, and payment for the high-quality services rendered is necessary to keep the doors open.

The development of the CP is the only time that the physician should be involved directly with the collection process. Agreement on both the financial and collection policy is essential. When the patient asks for special consideration of payment terms, the physician can indicate that the staff is the source of dealing with financial matters, the physician "only" deals with the patient's medical needs. Physicians should stay out of the daily collection process.

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Policies for Managing Your Revenue Cycle
(Continued)

Verifications should be required prior to the first and all subsequent visits. Obviously, if a patient returns each day for a week this would not be necessary. However, even an every-other-week patient may have insurance changes occur, and it is strongly recommended that every patient visit in this context should be verified. This will assist with routine claims processing, but also awareness as to the status of the patient meeting the annual deductible. The front desk staff is thus aware of the amounts to be collected at the time of the visit.

Very often patients use excuses related to the need to make payment at this time. The staff should develop and utilize scripts for collection. For example, when asking the patient for payment the staff should not say "Your co-pay is $20." Instead they should indicate that "The co-pay is $20, will you be paying by cash, check or credit or debit card?" (Note the cards accepted: VISA/Master Card, etc.). In this way the answer has to be one or the other and not a simple refusal. Scripts should be developed for all scenarios including: I didn't bring my check book; I don't have any cash; I don't have a credit card; or I mailed my check yesterday.

The processing staff should also make a note in the patient's record (or on the daily schedule) of any prior balance amounts due, to assist the front desk staff in collecting those balances. The absolute best time to collect is when the patient is face-to-face with the staff.

Policies for Managing Your Revenue Cycle
(Continued)

In addition to addressing patient payments, the CP should spell out the office procedure and time frame for submitting insurance claims. This includes the timely completion of the encounter form. The goal is to complete this information at the time of visit, or in the worst case, by the end of that day. The complete list of CPT codes and appropriate diagnosis codes noted on the encounter form is critical for clean claims processing.

In some offices, the physician selects the codes and submits them at the time of completion of the patient's visit by noting it in the electronic health record. At other times, this information may be written on the encounter form and forwarded to the charge entry staff for review and completion. Each practice should clearly spell out this process.

If the physician enters the data, a random audit should be conducted to insure that nothing is lost and that the decision-making is appropriate for the documentation. Typically this is done by someone who is knowledgeable about coding for the type of practice.

Once the data has been entered and reviewed by the end of the day, the claims should be flagged for processing. That evening's submission through the clearinghouse will generate a report for review the next morning and will indicate if there is a problem with a claim. The processing staff should immediately review the issue and reflag the claim for processing that evening.

Once the claim is submitted, patience is required. Familiarity with the managed care contract is necessary to insure the claim is processed in the time frame specified in the contract.

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Policies for Managing Your Revenue Cycle
(Continued)

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An EOB, or electronic remittance advice (ERA) is received from the clearing-house. The time frame for processing should be stated in the CP. All checks received should be deposited that day, and all EOBs or ERAs received should also be posted to the patients' accounts by the end of that business day.

The payment posting process will include an identification of a denial or underpayment on line items noted by the payer. The CP should indicate what is to be done in each of these circumstances. A log of denials including reasons and payers should be developed. This information should be analyzed to identify what and why the denial exists in the first place. A denial caused within the practice results in "re-work" which is a waste of time. The goal should be DIRFT – Do It Right the First Time – and education and awareness of what happened should occur with the initiating staff. Industry wide, the majority of internally generated denials come from wrong demographics or insurance information.

In any event, the denial should be researched and the line item repaired. This corrected claim is then sent to be re-processed per the terms of the contract. If a simple re-submission is adequate, or a letter of explanation is required, this should be completed as soon as possible. There are very often time frames for dealing with denials in the managed care contract.

There are also specific instances such as an outright refusal to pay that result in the need to develop a written appeal letter. This letter may require a specific note from the physician, a copy of the medical record or other pertinent information. There also may be "routine" denials that can be dealt with through an already developed template where the staff fills in the specifics and re-submits the claim.

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Policies for Managing Your Revenue Cycle
(Continued)

Your practice should have an understanding of the fee schedule associated with each payer. At a minimum this should include at least the top 20 or 30 CPT codes. If possible, these should be loaded into the practice management software, and the payment poster will recognize and flag the claim if there is an underpayment. If not loaded into the software, the payment poster should have a list of these main codes and the expected payment amounts associated with each code.

The CP should identify what steps are to be taken for an underpayment. Again, there needs to be an overall understanding as to the impact of this. For example, if the amount paid is $1.00 less than expected, should the claim be appealed? Remember, that an underpayment of this "little" amount may occur often and so the cumulative amount could be substantial, and therefore may be worthwhile appealing.

Once the insurance amounts are appropriately applied to the patient account, the balance should be noted as patient responsibility. The next time statements are processed, the patient is thus initially informed that the account is now their responsibility.

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Policies for Managing Your Revenue Cycle
(Continued)

Handling Delinquent Accounts

A good question to discuss when developing the CP is what constitutes a delinquent account. It is recommended that this be after two statements have been sent.

Once the patient has received the second statement and payment has not been received, the CP should spell out the next steps. These may be as follows:

- The account is brought to the attention of the patient's physician.
- The physician reviews the account and indicates what the staff should do next:
    - Write off the balance
    - Start the collection agency process
    - Pursue some other source of payment

In those cases where the physician has indicated that the patient account should be turned over to a collection agency, a third notice is sent. This could be in the form of another statement with a note indicating that if the balance is not received or the patient does not contact the practice, the account will be referred to a collection agency.

Another option is to not generate this notice from the software. Instead, use an "invitation" or different color envelope and hand write the patient's name and address, indicating the same information. This may sound like unnecessary work, but the patients are more likely to open an envelope that is hand written than one they have seen before and know is a statement from a computer.

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Policies for Managing Your Revenue Cycle
(Continued)

A relationship with a collection agency is problematic; they charge a percentage of what is collected either by them or the practice. The key is to maintain a good relationship to insure adequate reports and effective communication.

The CP should also identify what should happen to those patient balances that are a "small" amount, such as $10. The patient should receive one more statement, and then statements stop, with a note placed on the account stating that when the patient returns this balance is still due. It is estimated that the cost of processing a statement is $8.75 each. This includes not only the obvious postage and forms but the system use, staff review, etc. It is more cost-effective to collect these types of balances in person at the time of the next appointment.

The second most effective approach to collections is with a phone call. However, there is a cost benefit in this approach. First, whenever a patient calls to ask a question, respond in a positive manner. If there is something left unanswered, research it and return the call. The more information the patient has, and the more responsive the practice is, the better the chance of collecting the balance due. When placing a call to the patient to ask about the status of a payment be forthright, committed, but empathetic at the same time. There is an art to collections over the phone. Also, set a dollar figure that you will call. It is not worth the staffing expense to call on a $15 account, but might be for a $100 balance.

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Policies for Managing Your Revenue Cycle
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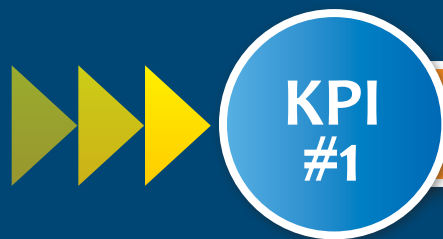
The cost of the collection operation needs to be considered when reviewing the resources necessary to collect the amounts due. The cost of statements, the cost of the credit card processing fee, staffing, space, software – maintenance and upgrades, etc. – factor into an overhead cost that is not easy to manage. One key is the cost of hiring, training and maintaining adequate staffing. This is a high pressure area within which to work. If dollars aren't collected, the pressure can be great on the staff. Thus this area of the practice normally has a high turnover. It is estimated that to replace an employee who leaves, the cost is approximately 70% of the annual pay. Therefore, if an employee is paid $10 an hour, the effective cost of replacement is $14,000 (2,080 normal hours worked at $10 per hour = $20,800). This is not the total out-of-pocket cost, but does include intangible costs such as training, reduced productivity, etc. The more stable the processing department, the better it is for the practice.

consider all of the costs related to collections

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Key Performance Indicators

A key performance indicator (KPI) helps the physicians/owners understand how well the revenue cycle is being managed. There are many items necessary to report on, but there are three major KPIs that should be monitored on a monthly basis.

KPI #1

Days in Receivables Outstanding (DRO)

The three major KPIs that should be monitored on a monthly basis include DAR, AR over 120 days, and net collectible percentage.

The first KPI is the Days in Receivables Outstanding (DRO). This statistic indicates how quickly the charges posted are paid by the various payers. The lower this number is the better. Calculate DRO by adding your current total receivables outstanding and the sum of your credit balances. (Adjusting for credits is important, as credits offset receivables and so can mask performance.) Divide that figure by your average daily charge. Here's the formula to calculate the DRO:

$$\frac{\text{Total outstanding accounts receivable} + \text{sum of credit balances}}{\text{Average daily charges}}$$

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Key Performance Indicators (Continued)

KPI #2

Days in Accounts Receivables Over 120 Days

Your DRO should be 30-to-35 days. If it's over 65 days, you should be very concerned.

It is best to look at a minimum of 90 days, preferably the last 12 months, to determine the average daily charge. In other words, total charges posted over the past 12 months divided by 365 will achieve the denominator. At any point we would know the relevant amount of dollars outstanding.

Because of electronic claims submissions and electronic remittances (the Medicare policy of paying electronic claims in 14-to-17 days) this number should be 30-to-35 days. It varies greatly by specialty and by the payer mix.

The second KPI is the days in accounts receivable over 120 days. This simply means to look at the aged trial balance and identify the dollars outstanding in the bucket 121+ days. It may be necessary to combine several buckets since some software reports in several more buckets. The goal should be that no more than 10-to-15% reside in the 120+ days bucket. This number is typically higher than that found in the 91-to-120 day bucket since accounts may be significantly older. These accounts are the more difficult ones to collect due to such things as automobile accidents, payment plans and ones in appeal. A word of caution here is to insure that there is not an artificial "write off" of older balances. It is necessary to review a report with the reasons for adjustments. The lower this number is the better.

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KPI #3 — Net Collectable Percentage

Key Performance Indicators (Continued)

Your KPIs should be reported and tracked on a monthly basis to be sure the trend line is positive.

The third KPI is the net collectable percentage. This statistic tracks the percentage of eligible dollars expected to be collected vs. the amount actually collected. If the software has the contractual amounts for each CPT for each payer, it is fairly easy to obtain the number. If not, the following formula will provide the number.

$$\frac{\text{Payments for the period}}{\text{Charges-Adjustments}}$$

The higher this percentage the better, since the difference between this and 100% is the amount of bad debt associated with the practice. The standard here is 95-to-98%. With the increasing number of high deductible plans, the under insured, and the uninsured, this number has actually gotten lower or worse.

These KPIs should be reported and tracked on a monthly basis to insure the trend line is positive. A month where there is a change is a leading indicator to potential problems. These statistics also monitor the performance of the processing department. Too often the only number that is considered is the deposits, which is nice but is not an indicator of how well the business is progressing.

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Key Performance Indicators (Continued)

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There are other statistics that can be helpful including the charge, payments and adjustments by payer which means the three KPIs can be applied not only to the practice as a whole but to specific payers. Today, most practices have five or six major payers and each of these could be KPI monitored. The practice can then determine if the terms of thee contracts are being met effectively.

Communication and Education Are Key

All this information is great and can be effective IF there is adequate communication and education associated with its implementation. Everyone on the team should be intricately aware of the FP and CP for the practice. This means regular meetings to review the KPIs and discussions about the impact that each individual has in improving those numbers. Each new employee should be introduced to the FP and CP, as well as the expectations associated to with the revenue cycle management program.

Effective communication from the processing department to the front desk is essential when monitoring denials related to demographic and insurance information. A project team could be created to review why there are errors. It could be that the front desk has too many tasks to accomplish, there are too many interruptions, or they don't understand the importance of their role in the RC program. It may not necessarily mean that the front desk staff is not capable of doing the job correctly.

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Key Performance Indicators (Continued)

After the initial training, annual training and project reviews, there will be sufficient benchmarks within which to measure performance. A key factor in success is holding those responsible accountable for their performance. This is why the sharing of KPIs or other key data points is critical to long-term success. If training occurs but no one is monitoring performance, the efforts are for naught. Creating the awareness is part of the equation. Including the RC success rate into the annual employee evaluation or contract review program is essential to insure that the desired results are achieved.

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Options For Success

As has been discussed, this area of the practice is very complex and requires specific guidelines to achieve success. The practice should make a decision if it can, or should be able to, do all component parts itself, or if there are other options.

One option is to hire the staff, maintain the equipment, etc. and manage the entire RC internally.

Another option to consider is the use of an outside medical billing service. This service would contract with the practice to do those items noted in the processing department. This is the largest and most complex part of the RC program.

A medical billing service is a viable option for any of three scenarios that may be faced by the practice.

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Options For Success
(Continued)

For a practice that is just starting to look at their RC, a medical billing service is a way to eliminate one major headache from the start up checklist. This service can provide the link to the desired practice management software. The processing staff would not be part of the practice payroll, eliminating the time and effort required to recruit the desired skill set; someone else has that responsibility. The medical billing service can assist in setting the fee schedule, monitoring the payer contracts, developing the encounter form, and more. At the same time the accountability for ongoing collection is clearly defined in the medical billing contract to insure that the practice knows where there are issues.

For the existing practice that believes the revenue cycle is not effectively managed, it is a viable option to seek outside assistance. A quality medical billing service eliminates the turnover and processing department training issue, as well as provides a professional team to relate closely with the internal aspects of the revenue cycle program.

For those practices that currently choose to contract with another agency, after reviewing your KPIs you may find that it is time to compare medical billing services. The key here is to look at the track record of other services, identify what their approach is to collections to assist in refinement of the CP, and to know what reporting they can offer to insure that there is adequate monitoring within the KPIs.

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Options For Success
(Continued)

The key in any of these scenarios is the need to look at the medical billing service as a partner. They must work closely with the other aspects of the revenue cycle to insure success. Consider these questions:

• Who will be the representative to communicate and help train the staff?

• Who will be doing the actual charge entry and/or account follow up?

• What are the procedures for processing claims? Is their clearinghouse reliable?

• What is their approach to patient statements and handling phone calls?

• How transparent is the medical billing company in sharing your information such as the EOBs?

The key is for the medical practice to have its direction in focus and to consider what the optimal approach is to managing the entire revenue cycle.

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Entrust Your Medical Billing to the Experts

Your revenue cycle management is too important to your practice to entrust it to people without the time and experience to execute it correctly.

Are you confident that your billing staff or small medical billing service are able to handle the complexities of today's medical billing, particularly with ICD-10 around the corner? If your denials are increasing, or your Days in Receivables Outstanding KPI is rising, the chances are not good.

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- **On average, our physician clients get paid faster than 75% of multi-specialty group practices** nationwide as surveyed by the Medical Group Management Association and Healthcare Billing Management Association for Days Revenue in AR.

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