Quest Diagnostics™

The 5 stages of revenue cycle management grief

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The 5 stages of RCM grief

For many physicians, making a positive impact on patient lives is what brings them back to the office each day, despite the long and often strenuous hours required. Meanwhile, the operational and financial aspects of running a practice can feel like barriers to focusing on care delivery. As a result, some physicians may subconsciously avoid or undervalue the role that these business functions have in healthcare.

The truth is that the financial health of a practice is nearly—if not equally—as important as the services it provides. The profitability of a practice enables physicians to pursue their altruistic objectives, and can even enhance the care provided. Additionally, these processes can have a tremendous effect on the overall patient experience.

Nothing has a greater impact on the financial health of a practice than the people and processes behind the billing. Whether it is managed in-house, or outsourced to a trusted partner, it is critical to keep a finger on the pulse to ensure that every last dime is collected.

In late 2018, Crowe, a public accounting, consulting, and technology firm, conducted research to determine the top healthcare revenue cycle risk areas for 2019.[1] Their analysis determined that medical billing and collections would be a top risk factor, due to patient access, greater patient-payer responsibility, and the increasing complexity of those processes. Together, these challenges escalate the risk of inaccurate billing, which can lead to rejections, denials, resubmissions, appeals, and diminished reimbursement. Similarly, a 2017 Black Book Revenue Cycle Management (RCM) survey concluded that 83% of physician practices with under 5 practitioners said the slow payment of high-deductible plan patients are their top collection challenge, followed by the difficulties that staff encounter communicating patient payment accountability (81%).[2]

The intricacies of today's medical billing processes come with a wide-array of challenges, which can result in substantial grief and loss. Our objective is to help you recognize and prevent the five most common concerns affecting RCM. Providers experiencing these symptoms should take note and seek out solutions quickly before minor issues grow to threaten the profitability and longevity of their business.

Are your RCM processes leaving money on the table?

Check the financial health of your practice with this easy online calculator. In just a couple of steps, you can quickly discover how your billing compares to best practices.

STAGE 1:
CONFUSION AND FRUSTRATION

The earliest indication for potential issues within your RCM is an increase in patient or office staff confusion and frustration. Are employee stress levels rising? Have patient billing complaints increased? Maybe some of your usually reliable account managers seem to be dropping the ball more frequently. In the moment that these problems occur, it is easy to pass the blame onto your office staff or even clients. As such, it is important to take a step back and attempt to analyze the situation from a logical standpoint. Ask yourself what the source of the confusion and frustration might be, rather than who is at fault.

In many instances, complications take root in innocuous ways. Here are some examples

Poor patient communication: Whether your team has limited availability or struggles to communicate the complexities effectively, that inability to converse clearly with patients can create a quagmire of delayed payments and frustration. Your personnel must be afforded adequate time and training to review financial policies with clients to avoid confusion. In a best-case scenario, your team will be equipped to avoid patient confusion by providing them with estimates for services, and options for payment plans. The most effective teams are equally adept in customer service as they are in managing the revenue cycle.

Insufficient training: Too often, employees within health organizations struggle to describe how their roles influence financial outcomes. Every member of your practice should understand the significance of required procedures, as well as what aspects of their daily routines are most crucial to success. Errors, information gaps, and lack of attention to detail are all side effects derived from insufficient training. Those responsible for billing should also be thoroughly trained on the policy guidelines and coding requirements of each insurance payer to support the claims process.

Lack of transparency: While patient care should be the top priority for physicians, it is also important that they fully understand the financial health—and risk—of the business. Regular meetings between physicians and office managers are essential for monitoring the well-being of the organization. When communication between these two parties is limited, the risk of problems grows substantially, and early symptoms could be overlooked.

Informal financial policies: Establishing sound monetary policies may seem obvious to some providers, but many health organizations operate without them. Both employees and patients can benefit, as it provides structure and clarity around fiscal procedures. An effective policy should include considerations for customer responsibilities, unpaid balances, and denied claims. Prior to implementation, legal counsel should review any such document closely.

STAGE 1: CONFUSION AND FRUSTRATION

Procedural inefficiencies: In any office environment, increasing workloads and responsibilities can creep up slowly and eventually overwhelm. Employees may find themselves multitasking more frequently, resulting in longer project timelines that can cause delayed invoice delivery and extended coding times. Burnout due to increased responsibility can also hinder your efficiency. By communicating with employees regularly and monitoring their assigned tasks, team leaders can identify inefficiencies expeditiously, helping to prevent delayed reimbursements.

Addressing these obstacles promptly is less burdensome and poses fewer risks than when left untreated. Countermeasures can be as simple as educating staff members and rearranging workflows to ensure that they are afforded sufficient time to speak with patients and undergo necessary training. If you are unsuccessful in addressing these impediments independently, it may be worthwhile to hire additional help, seek the advice of a professional, or consider outsourcing your RCM services entirely. Whatever solution you decide to implement, commit to making that change now to prevent additional instances of RCM grief, as outlined below.

STAGE 2: ERRORS

In the event that confusion or frustration surrounding RCM procedures is left unchecked, the next stage of grief that you are likely to encounter is an influx of errors and inaccuracies. The two factors most commonly prone to mistakes are patient data and coding.

Collecting complete and accurate patient information is critical to the speed and effectiveness of your revenue cycle. If your staff is not provided sufficient training, opportunities for inaccuracy within patient demographic and insurance eligibility details rises substantially. This can then lead to a variety of headaches, including improper billing, denied insurance claims, and lost reimbursements. By ensuring that patient data is collected and verified at the outset, you can help to prevent this from occurring.

Automating your data collection operations can create additional safeguards, minimize human error, and reduce workforce burden. Examples of this include automating check-in, registration, pre-eligibility, and prior-authorization tasks. Not only does this help reduce opportunities for error, it also allows for frequent and fast verifications at the time of scheduling, immediately prior to the appointment, and throughout the patient experience. By supplementing standard workflows with automation, you can dramatically improve informational accuracy.

Coding can also be prone to similar errors due to a lack of training. Requirements from payers and the Centers for Medicare and Medicaid Services (CMS) are continually increasing in complexity. If office managers do not remain current with modern protocols, you may find yourself experiencing more frequent delays and rejections in your revenue cycle. Some of the most common errors arise from improper diagnosis documentation and the use of non-specific diagnostic codes or incorrect modifiers.

There are numerous ways physicians can tackle the challenges of coding accuracy. Make it a priority to provide billing managers with ongoing training based on CMS guidelines. Education can take the form of formal courses or simply keeping up on related news and changes. For example, CMS offers quarterly updates on code modifications, which managers can subscribe to receive. Additionally, some medical billing software applications offer a claim-scrubbing utility to check accuracy. This an excellent method for conducting audits without consuming valuable time and resources.

STAGE 3: CLAIM REJECTIONS AND DENIALS

When errors occur, rejections and denials are likely to follow. Human error can occur at any stage of your revenue cycle, regardless of how many preventive measures you take. However, occurrences of rejections and denials should not be taken lightly. Your practice could already be incurring substantive losses in your revenue stream and it is imperative that you take steps to control these factors immediately.

According to an American Academy of Family Physicians (AAFP) report, the average claims denial rate across the healthcare industry is between 5% and 10%.[3] This data is complemented by research published in Health Affairs, which estimates that the healthcare sector encounters as much as $54 billion in challenged revenue annually.[4] And while on average, 63% of these claims are recoverable, providers could still find themselves paying as much as $118 per claim in appeals-related administrative costs.[5]

If your practice is encountering a high rate of rejections or denials, your first step is to monitor and analyze them systematically in order to better prevent and manage such occurrences moving forward. Track the number and cost of denials and categorize them based on their root causes. A prevention plan can then be established based on any trends observed, beginning with the most costly claims. This plan should also incorporate a method for tracking and measuring success, with the goal of reducing your overall rejections and denials to 1% or less. If your practice lacks the knowledge or bandwidth to create and manage a prevention plan, you should consider outsourcing to help prevent additional lost revenue.

STAGE 4:
CLAIM RESUBMISSIONS AND APPEALS

When a practice encounters a rejection or denial, resubmissions and appeals will be required to recoup lost revenue.

Rejected claims are those that do not adhere to the specific formatting or data requirements set forth in the CMS guidelines. When they occur, the claims are not fully processed by the payer, allowing providers to correct errors and resubmit. While this can be a tedious process, resubmissions can be addressed quickly with the appropriate measures in place.

Alternatively, recouping the revenue of a denied claim requires a far more arduous process. Unlike rejected claims, denied claims have already been received and fully processed by the payer with a negative determination made. As a result, these claims cannot simply be corrected and resubmitted. Instead, providers must investigate the claim to determine the cause for denial and provide an appeal or reconsideration request.

Claims appeals can be a time-intensive and costly process, as each payer has unique protocols in place. According to a study published on the JAMA Network, the estimated processing time and total costs for billing and insurance-related activities were 13 minutes and $20.49 for a primary care visit.[6] If you were to multiply this data by the average number of patients per day and the number of days worked per year, the results are substantial in value. Additionally, even if an appeal is submitted, there is no guarantee that full collections can be achieved, further adding to the costs associated with these activities.

The challenges are even more daunting when dealing with Medicare reimbursements. In a recent MGMA Stat poll, 67% of medical practices reported that 2019 Medicare payments would not cover the cost of delivering care to beneficiaries.[7] Additionally, the US Department of Health & Human Services (HHS) website shows that the current average processing time for appeals before an Administrative Law Judge in 2019 was more than 1,300 days.[8]

The most effective way to minimize the operational and financial impact of denials is to react quickly and remain vigilant. Review denials on the day that they are received and respond to them within a week of receipt. Resubmissions and appeals have an expiration period. Prompt attention not only avoids missed deadlines, but also helps expedite reimbursement overall. One effective tactic for expedient response is to maintain an up-to-date record of appeal guidelines for each payer. This documentation can help ensure that submissions are fast, accurate, and compliant, preventing further delays. Your billing managers should be diligent in following up with payers after submission. Disregard any concern over being perceived as annoying or overbearing, and continually pursue the revenue that is owed to you. Achieving a more robust, predictable, and sustainable cash flow is worth the effort.

STAGE 5:
DELAYED OR UNPAID PATIENT PAYMENTS

The continually increasing prevalence of high-deductible health plans with greater requirements for patient responsibility has forced healthcare providers to rely more heavily on consumer payments. To demonstrate, a recent TransUnion Healthcare analysis of patient payment responsibility found an 11% increase in average out-of-pocket costs during 2017, increasing from $1,630 in Q4 2016 to $1,813 in Q4 2017. Additionally, this analysis revealed that 49% of patient out-of-pocket costs per healthcare visit were below $500; 39% were $501-$1,000; and 12% were more than $1,000.[9] At these values, delayed or unpaid patient financial responsibility can have a significant impact on revenue, even after managing the insurance payer responsibilities.

The effects of delayed or unpaid payments reach further than just the immediate revenue impact. Collection efforts stretch internal resources thin by incurring additional patient outreach and interaction. In some situations, organizations may even require the support of debt collection services. This can be a hindrance to the cost and efficiency of your RCM.

To increase the effectiveness of collections, providers must adjust their policies to align more closely with the expectations and best practices of the consumer market. As reported in a recent Black Book survey, 92% of healthcare consumers stated that improving the customer experience should be a top priority for medical providers.[10] Based on this feedback, providers should consider the following actions.

- Communicate financial policies to patients effectively prior to service
- Educate patients on the details of their specific insurance plan
- Estimate patient-payer responsibility up front to ensure awareness of the costs they are expected to pay
- Educate front-office staff on requesting payment at time of service for the current visit, as well as any outstanding balances
- Collect payments up front through point-of-service or pre-service payment options
- Provide a method to collect co-pays, deductibles, and co-insurance balances online
- Offer flexible payment plan options that minimize the impact of large, lump-sum balances
- Follow up with accounts receivable via timely and frequent patient communications

By considering your own experiences and expectations as a consumer, you can begin to create a more patient-friendly billing process that helps improve collections and enhances the complete patient experience.

GETTING PAST THE GRIEF THROUGH OUTSOURCING

According to a HIMSS Analytics survey, nearly one-third of respondents stated that they still rely on a manual process for denial management.[11] Manually managing your revenue cycle remains highly prone to human error. Many small practices operating under thin margins may find these tasks to be overwhelming, draining an already limited pool of internal resources. In this situation, outsourcing billing activities becomes prudent.

Quest Diagnostics recently conducted a national survey on revenue cycle management.[12] According to respondents, denials from insurance, denials from Medicare/Medicaid, and difficulty collecting patient payments were the top three biggest pain points in their billing process. Additionally, approximately 40% of respondents shared that their denial percentage rates were above the national average of 18%. When asked about the most compelling features of a medical billing service, the top three responses were time savings and overall efficiency, denial management, and increased collections, respectively.

Outsourced billing can offer your practice more expertise, improved collections, and readiness for changing reimbursement models if you hire the right service, and you manage the relationship effectively. Before investigating the myriad RCM services available, you should first determine what goals and expectations to set for your business and potential vendors. Some questions to consider include

- What distinct revenue are you targeting?
- What are the biggest gaps that need to be filled in your revenue cycle?
- What specific services do you expect from a vendor?
- How quickly do you expect to see denial rates improve?
- What level of customer service and support do you expect to receive?
- How much involvement do you expect your staff to have in vendor oversight?

Comprehensive RCM solutions should offer the ability to track patient interactions from registration, to scheduling, throughout care, and through final payment. These tasks are typically handled by a service provider for a percentage of collections or for a subscription fee. One advantage is that it integrates technology from start to finish and automates numerous functions so that physicians can maintain focus on clinical care.

GETTING PAST THE GRIEF THROUGH OUTSOURCING

When evaluating potential RCM services, healthcare organizations should seek out a trusted partner that can provide the following capabilities.

- Patient scheduling and verification of insurance eligibility
- Acquisition of patient insurance card and photo identification
- Collection of patient co-pays, deductibles, and outstanding balances prior to service
- Preparation and submission of insurance claims and patient statements
- Quality assurance reviews to check coding and billing for compliance and accuracy
- Claim reviews from insurance companies
- Management of denials, rejections, resubmission and appeals
- Customized reporting to monitor claims, KPIs, and financial reporting
- Payer or patient outreach to collect payment of outstanding balances
- Seamless integration with your EHR platform

The best RCM services furnish on-demand reports and a practice dashboard to help staff see at a glance where the business stands financially. Access to this information can help identify strengths and weaknesses throughout the revenue cycle. Dashboards convert data into insight, identifying problems and allowing organizations to better manage accounts receivable.

An advanced medical billing service can also enable you to fully track denials with reports that record the number of claims denied and list them by reason and insurance plan. With this information in hand, you can review prior denials and look for trends. Preventive measures can be taken to adapt your routines, update codes, automate eligibility checks, and more.

SUMMARY

As your healthcare organization sets out to optimize its billing and collections, it is important to keep in mind that the financial health of your practice is essential to the care that you provide. By streamlining your operation, you can improve the patient experience while potentially creating a more sustainable and predictable revenue stream. Revenue that you can use to invest in equipment and employees to further advance your care-giving capabilities.

Establishing an efficient revenue cycle does not come without effort, but there are many resources available to help you along the way. By recognizing the various stages of RCM grief and applying the appropriate prescriptive solutions, you can more quickly and easily identify potential problems and put your practice on a path toward financial wellness.

SOURCES

1. Crowe. The top risk areas for healthcare organizations in 2019. Crowe.com. https://www.crowe.com/-/media/Crowe/LLP/folio-pdf/Top-Risk-Areas-for-Healthcare-Organizations-in-2019-HC-19005-015.ashx?la=en-US&hash=5D9BF468A6167ABA26287C72157B74E97E7070AD. Accessed August 23, 2019.
2. Black Book Market Research. Providers driven to implement patient-centric financial solutions as consumer payment responsibility skyrockets 29 percent, Black Book survey. Newswire.com. https://blackbookmarketresearch.newswire.com/news/providers-driven-to-implement-patient-centric-financial-solutions-as-20015628, Accessed August 23, 2019.
3. AAFP. Your revenue cycle: denial rate. AAFP.org. https://www.aafp.org/practice-management/administration/finances/denial-rate.html. Accessed August 23, 2019.
4. Gottlieb JD, Shapiro AH, Dunn A. The complexity of billing and paying for physician care. Health Affairs. April 2018. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.1325. Accessed August 23, 2019.
5. Change Healthcare. Change Healthcare analysis: $262 billion in healthcare claims initially denied in 2016. Changehealthcare.com. https://www.changehealthcare.com/press-room/press-releases/detail/262-billion-in-healthcare-claims-initially-denied-2016. Accessed August 23, 2019.
6. Tseng P, Kaplan RS, Richman BD, et al. Administrative costs associated with physician billing and insurance-related activities at an academic health care system. JAMA Network. 2018. https://jamanetwork.com/journals/jama/fullarticle/2673148. Accessed August 23, 2019.
7. Medical Group Management Association (MGMA). Medicare reimbursement falls short of care delivery costs. MGMA.com. https://www.mgma.com/data/data-stories/2019-medicare-reimbursement-rates. Accessed August 23, 2019.
8. US Department of Health and Human Services. Average processing time by fiscal year. HHS.gov. https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html. Accessed August 23, 2019.
9. TransUnion. Patient payment responsibility increases 11% in 2017. TransUnion.com. https://newsroom.transunion.com/patient-payment-responsibility-increases-11-in-2017. Accessed August 23, 2019.
10. Black Book Market Research. 19 recent healthcare tech start-ups attract instant consumer appeal, Black Book survey. Newswire.com. https://blackbookmarketresearch.newswire.com/news/19-recent-healthcare-tech-start-ups-attract-instant-consumer-appeal-20556737. Accessed August, 23 2019.
11. HIMSS Analytics. 2016 study finds low adoption but large opportunity in RCM denial management solution space. HIMSSAnalytics.org. https://www.himssanalytics.org/news/2016-study-finds-low-adoption-large-opportunity-rcm-denial-management-solution-space. Accessed August, 23 2019.
12. Quest Diagnostics Survey. Data on file, 2019.

Additional resources

- Quanum Insights Blog
- Quanum RCM Brochure

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