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healthcare

MGMA

CURRENT TRENDS IN PHYSICIAN PRACTICE
REVENUE CYCLE MANAGEMENT



RECENT ACQUISITION FRENZY

- Physician practice acquisitions have created a sense of urgency for Hospitals and health systems to complete these transactions quickly to remain competitive.
- Many of these organizations focused their initial attention on negotiating contract terms, conducting asset appraisals, and assigning vendor contracts while deferring considerations on how to manage the revenue cycle aspects of physician practices.
- Lack of preliminary planning regarding Revenue Cycle standards for physician practices result in a mixed bag of acquired practices that are both difficult to manage and unprofitable.
- In particular, inadequate planning and preparation can lead to poor performance in physician billing operations, as reflected in cash collections that are lower than desired, high accounts receivable balances, frequent write-offs, and patient/physician dissatisfaction.
- This lack of performance can necessitate major investments to right the physician revenue cycle ship.
- Key action steps in the early stages of building a physician enterprise will ensure the essential pieces of professional fee billing are securely in place.



REVENUE CYCLE “PUZZLE PIECES”

REVENUE CYCLE FRONT | MIDDLE | BACK



ADMITTING/REGISTRATION:

- Patient Check-in
- Completion of Forms
- Point of Service Collections
- Financial Counseling and Charity Care



PRE-SERVICE:

- Centralized Scheduling
- Pre-Registration
- Insurance Verification
- Pre-Authorization/Referrals
- Medical Necessity Validation



MANAGED CARE:

- Payor Contract Negotiations
- Manage Payor Relationships



HEALTH INFORMATION MANAGEMENT:

- ICD10 & CPT Coding of Inpatient and Outpatient Procedures
- Respond to Payer Requests for Records
- Medical Appeals Support

PATIENT FINANCIAL SERVICES:

- Claims & Patient Billing
- Accounts Receivable Management
- Claims Variance Review
- Payment Posting
- Technical Denial Management



CLINICAL SERVICES:

- Patient Treatment
- Coding and Documentation
- Charge Entry/Capture
- Charge Master Maintenance



CASE MANAGEMENT:

- Coordinate with Physicians
- Utilization Review and Discharge Planning
- Prevent Denials
- Medical Appeals Support





PIECE #1: CAPABLE MANAGEMENT AND A QUALIFIED TEAM

- A Physician Practice Revenue Cycle Director should be able to:
 - Ensure appropriate visibility of front-end processes that have an impact on the Revenue Cycle:
 - Scheduling
 - Patient Pre-registration
 - Insurance Verification
 - Patient Estimations
 - Establish and enforce performance and productivity standards for Billing functions:
 - Coding
 - Charge Entry
 - Insurance Follow-up
 - Payment Posting
 - Provide input on decisions regarding IT system selection and configuration.
 - Analyze data to identify, diagnose, and resolve billing issues quickly.
 - Exercise appropriate influence on matters pertaining to Revenue Cycle processes and procedures not only within the Billing office, but also across a large and sometimes bureaucratic organization.



PIECE #2: APPROPRIATE ORGANIZATIONAL MODEL

Centralizing vs. Decentralizing

- If the acquisition is early and the Hospital has not handled professional billing for physicians, Decentralized billing may be appropriate where the practices continue to bill with their legacy systems under a single tax ID.
- As the organization grows, a centralized approach can promote increased expertise, reduce errors, provide flexibility for new payment methodologies, and minimize exposure to compliance issues.
- In a hybrid model, functions that do not require face-to-face patient or physician interaction are centralized, while locally managed clinical support staff are still expected to adhere to common guiding principles under one revenue cycle policy.

Insourcing vs. Outsourcing Considerations:

- The current competence of staff in professional fee billing.
- The adequacy of the current electronic health record (EHR) or billing system.
- The ability of the current staff and systems to expand with the growth of the physician enterprise.



PIECE #3: SYSTEM FUNCTIONALITY

Consolidated Practice Management Systems:

- The impact that IT decisions can have on the revenue cycle is very important to consider.
- The most effective approach is to transition all acquired practices to a single practice management system that facilitates, provides, or enables the following:
 - Key Performance Indicators Reporting.
 - A consistent approach to primary work flows (i.e., registration and demographic collections, eligibility verification, A/R follow-up).
 - Electronic claims can be submitted real-time.
 - Management of all work flows at the site of service and remotely (i.e., centralized business office, scheduling call center).
 - Submission and management of both CMS-1500 and UB-04 claims forms to accommodate provider-based billing.
 - The ability to monitor payments variances/accordance with contract terms.
 - Payments can be posted automatically.
 - Integration with an EHR.
 - Easy segmentation of performance if multiple tax IDs are in use (i.e., charge and collections volumes, A/R), while still creating efficient work queues that enable staff to manage billing effectively.



PIECE #4: TRANSPARENCY, STANDARDS, AND CONTROLS

- Carefully manage productivity, backlogs, processing time, and error rates.
- Establish Productivity and Accountability measures to ensure staff obtains the appropriate information to avoid edit errors downstream.
- Clinics should be responsible for their own errors. Edits and Denials related to front-end errors should be routed back to the clinic for resolution.
- Establish productivity standards for the billing office and hold staff accountable. Example:

REVENUE CYCLE ACTIVITIES OCCURRING IN THE BILLING OFFICE	
Function	Example Control*
Insurance follow-up	Days since last follow-up activity
Patient follow-up	Outbound call volume per day, by worker
Payment posting	Transactions posted per day, by worker
Refunds	Refunds processed per day, by worker
Customer service	Inbound call volume per day, by worker

*Quality audits are a necessary complement to work standards for ensuring that staff do not sacrifice accuracy or take process shortcuts in pursuit of volume goals. Accordingly, volume targets may need to be adjusted depending on the level of accuracy required or desired.



PIECE #5: PATIENT SATISFACTION

Waiting Room Management:

- As value-based care moves to the forefront, patient satisfaction will become a key factor in driving profitability.
- Patients are modern consumers and increasingly expect convenience, speed, and efficiency with all their transactions.
- Eliminate patient waiting as much as possible.
- Develop standardized process of allocating patients to nearest location with available appointments.
- Confirm every single patient appointment.
- Accurately track all patient no-shows.



PIECE #6: APPROPRIATE INVESTING IN CODING & COMPLIANCE

- A well-trained and experienced billing team is the most important indirect driver of revenue at your practice.
- Knowledge of proprietary rules of each payer is essential.
- Timely filing methodologies must be carefully monitored.
- Experience appealing rejected claims is key.
- Ensure the charge submission process is efficient and claims are billed and adjudicated appropriately.
- Eliminate dual charge entry which is often associated with a mix bag of global billing vs professional fee billing.
- Practices that lack in these key areas may need to evaluate if they are candidates for outsourcing.



PIECE #7: PATIENT FINANCIAL SERVICES

- Ensure billing is performed in regular intervals at the Business Office. Billing staff is responsible for:
 - Account Follow-up
 - Cash Posting
 - Obtaining Prior Authorization – Services
 - Denial Resolution
 - Credit Balances
- Identify staff specifically dedicated to Charge Entry.
- Submit claims electronically when possible.
- Claims with edit errors are communicated to specific departments via work queues to resolve issues.
- Choose Billing software with comprehensive reporting capabilities, electronic tracking of billed claims and various other metrics.



PIECE #8: KEY PERFORMANCE INDICATORS

SAMPLE SERVICE LINE

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The national healthcare practice of DIXON HUGHES GOODMAN

SIDE ONE

Financial Comparisons

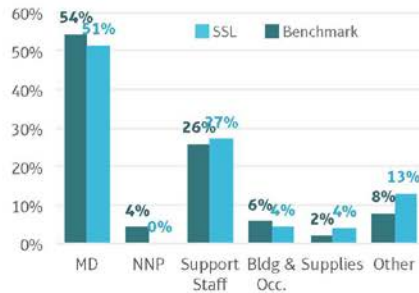
Comparing Financial Results with Industry Benchmarks enables organizations to understand performance within the context of peer groups.

MGMA Category	Benchmark	SSL	Variance
Total Med Rev	\$861,199	\$807,102	-6%
Operating Cost	\$438,308	\$491,879	12%
Total Med Rev after NPP & Operating Cost	\$487,576	\$315,223	-35%
Total Physician Cost	\$535,398	\$520,453	-3%

Notes: Total Med Rev calculated from 2014 Practice Analysis reports. Staff and provider expense are estimates as financials did not delineate these amounts clearly.
Benchmark: MGMA GI practice 2013 - per FTE MD.

Understanding expenses compared to peers in terms of cost category will assist in identifying opportunities for improvement.

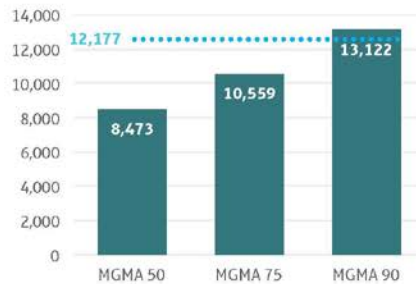
Total Category Cost Comparison



Productivity

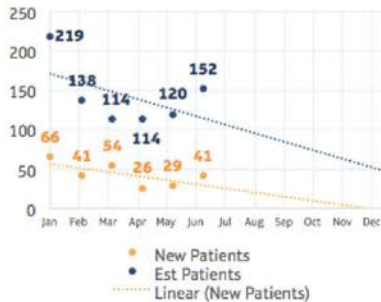
Analyzing productivity of providers compared to peer groups demonstrates if providers are producing at expected levels.

wRVUs Compared to MGMA



Examining trends in terms of new and established patients indicates scheduling efficiency and optimization and growth.

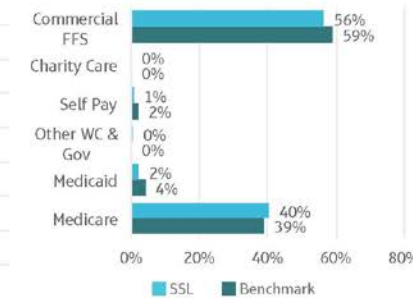
New & Est Patient Trending



Payer Analysis

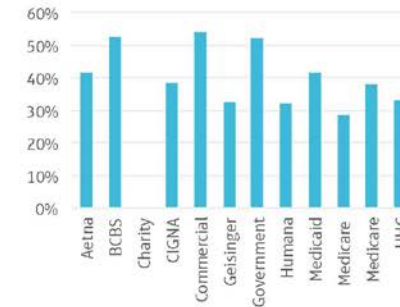
Understanding how payer mix correlates with peer groups provides insights relative to Financial Performance.

Payer Mix Comparison



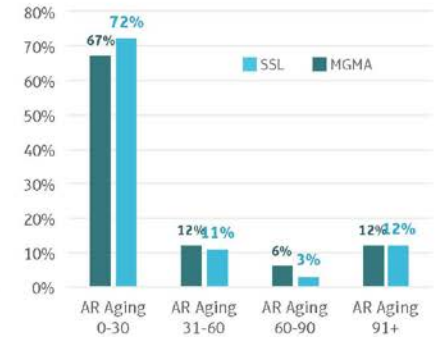
Identifying collection rates by payer will assist in contract management.

Collections by Payer



AR Indicators

AR aging analysis indicates if receivables are flowing through the Revenue Cycle in an expected manner in terms of timing. Best Practices have less AR in 90+.



Days in Accounts Receivable indicates the number of days worth of charges that are waiting to be collected. Best Practices collect quickly.

MGMA	Benchmark	SSL	Variance
Days in AR	28	29	↓ -1

First Pass denials represent the volume of unclear claims submitted to payers for adjudication. Best Practices experience 4% or less first pass denials.

Industry Standard	Benchmark	SSL	Variance
1st Pass Denial Rate	4%	2%	↑ 2%





PIECE #8: KEY PERFORMANCE INDICATORS (Cont.)

SAMPLE SERVICE LINE

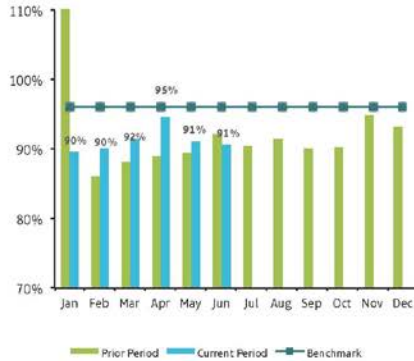
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The national healthcare practice of DIXON HUGHES GOODMAN

SIDE TWO

Adjusted Collections

Adjusted Collections represents the amount collected based on the estimated "collectable" dollar also known as "net collections." Best Practices collect a higher portion of the "collectable" dollar.

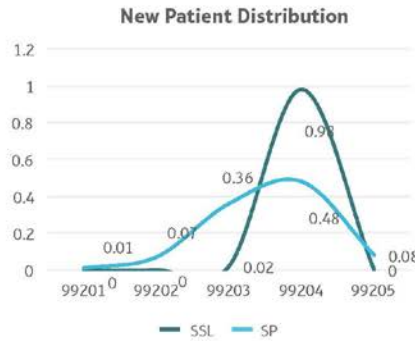


Unexpected Adjustments are non contractual adjustments and are a great roadmap for identifying opportunities for operational improvement.

	Unexpected Adjustments	
	Prior Year	Current Period YTD
Unable to collect	\$33,526	\$15,849
Courtesy	\$5,303	\$4,875
Error correction	\$80,607	\$89,092
MA 2nd	\$10,847	\$559
Non Covered	\$35,706	\$14,575
Copay Adj	\$425	\$7
Collection	\$2,333	\$-
Self Pay	\$380	\$-
Transworld	\$33,357	\$6,346
Total	\$202,484	\$131,303

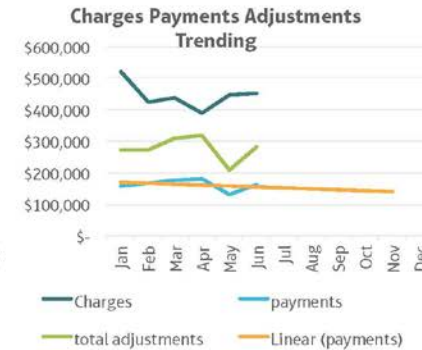
E&M Coding

Best Practices code for evaluation and management services with industry norms.



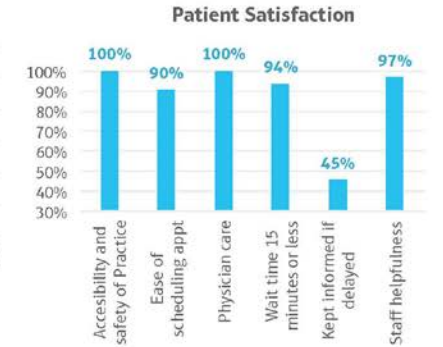
Outcomes

Trending Charges, Payments and Adjustments demonstrates overall volume activity and also depicts variances in Revenue Cycle routines (i.e., charge capture).



Patient Satisfaction

Understanding Patient Satisfaction Scores enables the Enterprise to proactively address issues.



Charge Lag

Charge Lag days represent the number of days between when a service was provided and when the charge was posted. Best Practices post charges more expeditiously than peers.

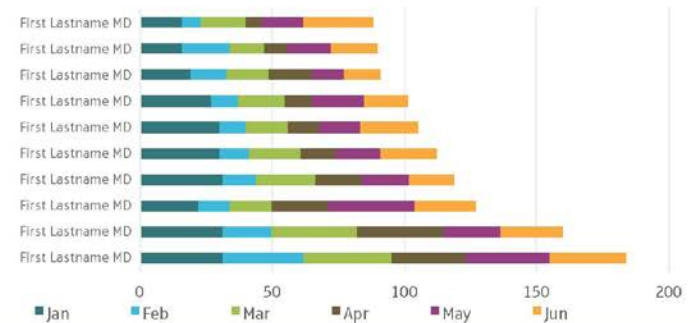
Charge Lag Analysis

Charge Lag	Benchmark	SSL
Charge Lag Average	2 - 3 days	1 - 5 days

Referral Analysis

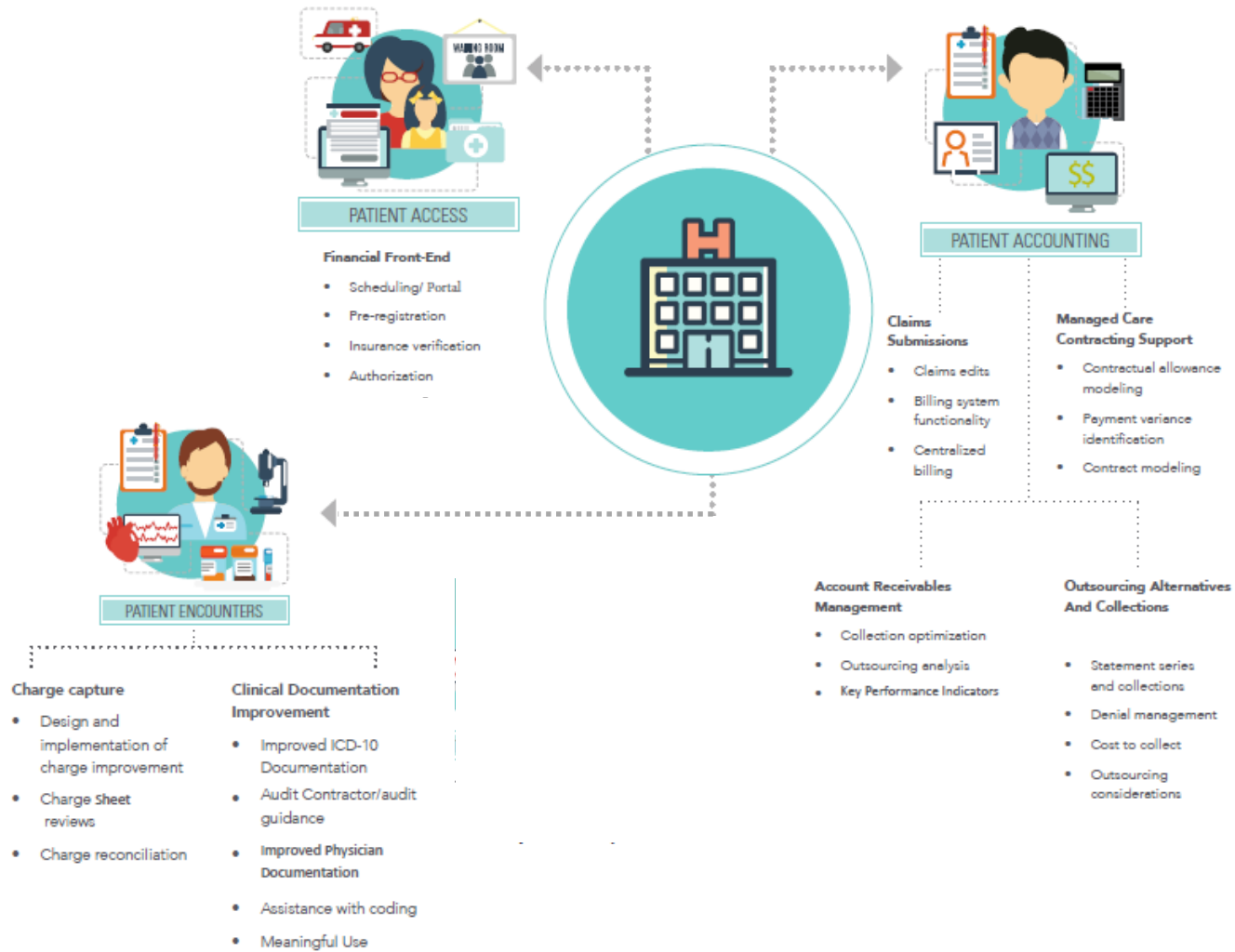
Trending referral information alerts the Enterprise to changes in patterns providing an opportunity to proactively manage relationships with top referring providers.

Referral Patterns-Top 10 Providers





REVENUE CYCLE SERVICES



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