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Three Strategic Approaches for Independent Physicians to Maintain a Healthy Revenue Cycle

With Tactical Methods to Improve Medical Billing and Coding

Content

As an independent physician, it's easy to get caught up in the day-to-day tasks of patient care and practice operations and management, pushing aside tasks associated with maintaining a healthy revenue cycle. However, maintaining a healthy revenue cycle isn't only important for the success of hospital systems: it is also essential for independent practices as well.

While it may seem daunting at first, assessing your practice's revenue cycle, making a plan to maintain its health and implementing that plan is in fact attainable. To help, here are three strategic approaches to maintaining a healthy revenue cycle that your practice can easily implement:

1. Negotiate with Payers
2. Maintain Healthy Accounts Receivable (AR)
3. Prevent and Reduce Unpaid Claims

Once you get into a healthy habit of improving your revenue cycle one step at a time, tasks that once seemed overwhelming will soon seamlessly transition to become part of your daily operations, give you peace of mind and help you maintain stronger financial health.

1 Negotiate with Payers

For independent medical practices, negotiating with payers is critical to revenue cycle health. While it's a necessary part of operating an independent practice, most physicians have had little to no experience doing so or have not seen much success in past negotiations. That said, there are a series of steps you can take for successful payer negotiations.

Come Prepared and Know Your Data

Before stepping into a payer negotiation meeting, it's important to do your research and come prepared with data to back up what you plan to ask for. Coming prepared with data such as patient satisfaction scores and metrics directly related to specific subsets of patients is a great way to show you're invested in your practice and know what you're talking about from an operational and strategic standpoint.

The more specific you get with your data, the better. Prior to entering a payer negotiation, be prepared to know your:

- Patient Volume
- Patient Charges
- Reimbursement History
- Reimbursement as a Percentage of CMS Published Rates
- Patient Co-pay and Deductible Payments as a Percentage of Patient Responsibility
- Reimbursement from Payer as a Percentage of Contracted Rate

Familiarizing yourself with payer-specific data is a great way to stand out, especially since, compared to the large amount of hospital-employed or large group providers in the U.S., an independent practice can be perceived by commercial payers as a small fish in a big pond. Although you know why your practice is special, a large insurer may not. Coming prepared to each negotiation with quantifiable reasons why your practice is different than the rest is an important aspect of renegotiating a contract you're happy with.

In a value-based world, knowing specifically where your practice adds value is important to document as well. Be prepared to know where your practice adds value in terms of:

- Patient Satisfaction
- Patient Follow-up
- Percentage of Patients Referred to Higher Levels of Care
- Reduction in Utilization of Labs, CT, X-Rays and Procedures for Each Measurement Period

Coming prepared to each payer negotiation meeting, and keeping track of the above data on a daily or even weekly basis can be easily done by taking frequent notes and communicating regularly with staff to ensure everyone is on the same page.

Approach Each Negotiation as a Collaborative Meeting

When entering a contract negotiation, knowing exactly what you want out of the meeting is a good approach to take. Additionally, taking the approach that the negotiation is a collaboration rather than a one-sided business meeting is a great way to begin.[1]

Before signing a contract, it's also important to look over the terms and make sure you understand what's at stake. Here are two things to know prior to signing a payer contract:

- **The reimbursement schedule.**
  This is important to the health of any medical practice, and is a process that begins when a patient first contacts your office. Understanding this can ensure your practice is prepared to meet important deadlines for maximum reimbursement. For example, larger payers may require a 90 day deadline to submit a claim while others, like Medicare, will give you 365 days.[2]

- **The claims filing data.** Understanding what data is required to file a claim under certain insurers is important. For example, Blue Cross Blue Shield of Rhode Island requires a strict set of data for submission, and if the proper patient data isn't provided that claim will be denied and a new claim must be submitted. Knowing this data is a great way to ensure you understand everything in the payer contract you're signing. [3]

It is also worth remembering that payer contracts negotiations are always flexible. While it may be easy to go with the flow and avoid confrontation, it's always best to stand up for what you believe you deserve.

2 Maintain Healthy Accounts Receivable (AR)

Maintaining a healthy accounts receivable (AR) is vital to the financial performance of your independent medical practice. However, it's easy to feel overwhelmed when trying to play constant catch up in order to get things back on track with your revenue cycle. Taking tangible steps to get your AR back on track is a great way to improve the overall health of your revenue cycle and practice's financial health.

Make Sure You Understand Your AR

Before you can improve your AR, you need to understand it. Once you know what areas are burdensome and financially unhealthy to your practice, you can work toward improving your overall AR one step at a time.

To better understand your current AR, first take a look at what areas of your AR need improvement. For example, if you notice you're receiving a lot of denials due to billing the incorrect insurance provider, this could be an issue that needs to be addressed with your front desk staff. On the other hand, if you notice an overwhelming issue with denials that are missing a modifier for a specific code, that may require addressing the coding side of billing. If the latter is the case, there could be room for coding education for those who are employed at you practice.

Coding education is offered by a variety of companies and can help train staff to catch coding errors that they usually would not know to catch. This education can ensure the proper submission of claims and, in turn, reduce denials within your medical practice, ultimately resulting in a healthier AR.

Coding education can supply your staff with the knowledge for:

- Having proper demographic and insurance information from a patient
- Ensuring correct procedure codes, diagnoses, modifiers and units are included in the claim prior to submission
- Improving medical record documentation to ensure content matches and supports services provided and codes submitted to payers
- Reviewing claims thoroughly prior to first submitting them
- Tracking AR trends to see if certain errors can be improved upon

Another alternative is using a reliable coding resource, such as X12 Codes, to understand claim adjustment reason codes that may be affecting your AR. Claim adjustment reason codes can explain why a claim or service was paid untraditionally, giving your practice further insight into understanding your AR and the codes tied to it.[4]

Download our pocket-sized Guidelines to Maintaining a Healthy Accounts Receivable for more AR best practices.

Download Now

Focus on Improving One Payer at a Time

Focusing on one payer at a time is a good way to start the process of actively improving your revenue cycle slowly but steadily. For example, some payers like Medicare take a longer period to process, meaning it may benefit your practice financially to start with submitting claims to them first, versus payers who have a shorter AR cycle.[5]

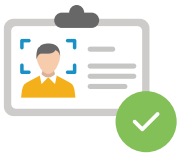
In addition, different payers have different rules. Profitable practices measure a number of different metrics for revenue cycle health, including first pass resolution rate (FPRR), which measures the amount of claims resolved the first time they are

submitted. Since a revenue cycle spans from the moment a patient schedules an appointment to post-visit tasks, like coding and billing, the FPRR is a great indication of your practice's revenue cycle length per payer.

First Pass Resolution Rate Calculation

Total number of claims resolved ÷ Total number of claims resolved during same period of time

Make Patient Insurance Verification a Priority



Checking patient insurance eligibility prior to a patient appointment is a vital step in maintaining a healthy AR. Such verification can give your practice insight into a patient's insurance specifics, including important factors such as their deductible and out-of-pocket cost per appointment. The best way to perform these checks is to make sure your front desk staff takes the time up front to collect all relevant information prior to each appointment. This information may include both personal and medical information such as contact details, insurance information and past history of medical conditions. Collecting this information affords your practice with a more organized patient verification strategy and could save your practice time and money in the long run. Additionally, many practice management systems offer an integrated insurance eligibility checking engine as part of their software. Results are then returned to the practice management system to assist the front desk staff in identifying patients that require additional verification.

Furthermore, if you're seeing a new patient, taking the time to make sure all information is spelled and entered correctly is a great way to make sure your records are accurate. If it's an existing patient, taking the time to make sure all information is reviewed and confirmed is a great way to see if information, such a patients personal contact information and insurance provider details, has been updated since their last appointment.[6]

3 Prevent and Reduce Unpaid Claims

Submitting clean and accurate claims to payers is a great way to maintain a healthy revenue cycle. The best way to do this is to map out a strategic approach for claim submission that aims to reduce denied claims. Although claim denials from insurers are apt to happen, there are steps you can take to make sure claims get paid even if they are denied.

Develop a Practice-wide Strategy to Deal with Denied Claims

Establishing a fast-acting strategy for dealing with denied claims is a good way to make sure all claims are corrected and resubmitted in a timely manner, both of which are important aspects for maintaining the overall health of your claims management process. Once your staff gets into a habit of reviewing denied claims quickly, it will become second nature.

When developing a practice-wide strategy, important components to stay as organized and efficient as possible include:

- Knowing the top codes, by both frequency and charges, utilized by your practice
- Monitoring your accounts receivable, by both payer and code, on a regular basis
- Monitoring reimbursement comments and denials
  - What reimbursement comments are being received?
  - Can you differentiate between expected and unexpected denials?
- Creating a plan of action for unexpected denials by code

Set Priorities

It's easy at first to try and take an all-in approach to improving your revenue cycle. However, while it's important to tackle all aspects of your practice's revenue cycle, it's also important to set realistic priorities to do so. **No matter the size of your practice, making an actionable list of priorities that are most important to your specific situation is a great way to start.**

For example, if you tend to have more problems with understanding denial codes, spending time familiarizing yourself with nurturing that process in order to improve and subsequently maintain a healthy coding strategy before moving onto the next pain point will be beneficial for your overall revenue cycle health. Once you and your staff feel comfortable coding claims properly, then it's safe to move on to the next hurdle.

Take Advantage of Outsourcing Opportunities

In addition to mapping out a strategy to prevent and reduce unpaid claims, utilizing outside support to assist in catching errors prior to submitting claims is a great way to streamline your process. According to the 2016 Black Book Report, 96 percent of practice owners say their billing processes are inefficient.[7] This is a very startling percentage that is successively leading to an increase in outsourced billing.

> If you're on the fence about outsourcing one or more parts of your revenue cycle and don't know if it will be best for your practice's financial health, having an in-depth cost analysis performed is a great way to make an informed decision.

Deep analysis can give you valuable pros and cons as to what outsourcing your revenue cycle could mean for the financial health of your practice.[8] Furthermore, outsourcing billing can save your practice money long-term and increase your profit margins over time. Both of these outcomes are inarguably beneficial and support the need for strategic plans.

Conclusion

Making a strategic plan to negotiate with payers, maintain healthy accounts receivable and prevent and reduce unpaid claims within your medical practice is a great way to work toward maintaining a healthy revenue cycle.

Although making a plan can be daunting at first, taking the time to make an informed list with actionable items is a great first step to get your revenue cycle back on track and in a healthy state. This approach will allow you to strategically grow and improve your billing process, steadily improving the financial health of your medical practice.

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