10 STRATEGIES TO OPTIMIZE CASH FLOW in a Medical Billing Office

The “unknowns” surrounding the current healthcare environment are pushing more and more practices to ask the questions “How can I know that my practice is performing at a pace that can keep up with the changing healthcare environment?” “How do I know my practice has the right tools to optimize cash flow?” “How do I move from good to great?”

And that list of unknowns is large:
• the supreme court hearing challenges to the mandatory coverage of Affordable Care Act (ACA)
• a recent survey demonstrating that 46% of the population has postponed medical care because of cost
• data privacy and security
• health insurance exchanges ability to really meet the deadlines when many states have yet to establish guidelines
• the explosion of social media to connect with patients - is it effective?
• IT costs, IT costs, IT costs
• the migration of physicians to new employment contracts with hospitals
• 5010 implementation
• start-up of ICD-10 conversion

Coupled with the unknowns, the “known’s” continue to plague many practices; reimbursements are down, costs continue to rise. Practices continue to be under constant pressure to deliver more with less and incorporate electronic solutions requiring them to spend more to comply. EHR implementation challenges are taxing many practices which can become a distraction to the revenue cycle processes.

Today more than ever, medical billing must receive constant attention to the right details. Practices have to become more productive and that productivity must be followed by “best in class” status to be considered a successful practice. What is it that separates better performing practices from other groups? According to a recent MGMA survey better performing practices excel in 4 areas:

- Profitability and cost management
- Productivity, capacity and staffing
- A/R and collections
- Patient satisfaction

That same survey stated that cost cutting and new sources of revenue probably won’t elevate the practice from good to great; however focus on billing processes, payment processes and managing accounts receivable will. Cash flow is the life blood of a practice and remains the single most important focus on the business side of medicine. That is the focus of this paper: 10 strategies to optimize cash flow in your medical practice. You will also be provided with tools to take that leap from good to great.
#1 - PROVIDER CONTRACTING/CREDENTIALING/ENROLLMENT

Although government payers have fixed provider reimbursement rates, third party carrier negotiations need to be approached by someone who can be an advocate for your practice. This individual needs to understand the business of medicine, know the rules, and be able to tenaciously work on your behalf to gain fair and proper reimbursement for your practice.

At the same time, close attention must be paid to provider enrollment and credentialing. Failure to follow time sensitive rules and carrier requirements can cost the practice thousands of dollars. Accountability for this process must be placed in detail orientated hands for optimal success. The purchase of software for larger practices can aid in storing and tracking the volume of data that carriers require. While each carrier may require different forms and multiple signatures, most want similar data.

“Need more predictable cash flow? Start collecting on the front end.”

#2 - INSURANCE VERIFICATION & CAPTURE

CONSISTENT COLLECTION OF CO-PAY/DEDUCTIBLE ON FRONT-END

Interaction between the billing office and the front-end of the practice is a critical step in the leap from good to great. The front-end must understand (through education and re-education) the critical role they play in ensuring provider productivity is paid appropriately and without delay. Capturing insurance card data, copying/scanning the card(s), is essential. Transcribing that data into appropriate coverage fields will mean the difference between timely payment and denial of claims, a costly and preventable denial. Preventing eligibility denials must be the focus of front-end personnel. With more and more MCR advantage plans, MCD HMO plans and the advent of health insurance exchanges; more and more accountability is being placed on the front-end.

A good exercise to make this point is to analyze the total volume of co-pays and deductibles due for a month. Need more predictable cash flow? Start collecting on the front-end.

Billing begins with booking the appointment. Taking advantage of having the patient on the phone and collecting this information PRIOR to the appointment can save time and also give opportunity to know what co-pay amount is due at the point of service (POS). Collection of co-pays and deductibles at POS is a key factor in better performing practices.
Updating practice management systems with new or changed information must happen before charges are entered into the system. This will ensure that changes in benefits, plans, or economic issues (i.e. layoff, unemployment) are captured appropriately.

The importance of this step cannot be over-emphasized. Practices who have thought they can hire minimally paid employees to “meet and greet” patients will quickly learn that this decision is costing them. Positive cash flow begins with collecting and recording accurate patient information.

#3 - CHARGE CAPTURE

With the introduction of “payment by outcome” and other ACA requirements, the implementation of EHR’s to document visits, procedures, and/or surgeries and the generation of an encounter form interface, documenting the charge correctly and accurately becomes paramount. ICD-10 will no doubt make “super bills” with pre-printed diagnosis codes for provider convenience almost obsolete. Practices will have to become more creative and informed on how to best capture the accurate information needed. It is not too early to consider options to that dilemma. That being said, by complying with clear and standard procedures, practices will meet any filing limits set by various insurance carriers.

At the same time, there needs to be a check and balance mechanism in place that affords staff the opportunity to ensure every visit/procedure/surgery has been captured. Many systems have software that can rack scheduled visits to the charge to ensure all eligible charges have been captured. It is simply not acceptable to the provider that a service performed is not billed.

#4 - CLAIM SCRUBBING

“Claim Scrubbing” (i.e. ensuring all carrier rules for payment have been followed prior to release of charge to carrier) is another critical step that can make a tremendous difference in the reduction of denied claims. Ideally, this needs to be performed prior to charge entry into the practice management system. This will allow the practice to make corrections to the charge that would have resulted in a denied claim. Scrubbing prior to an Account Receivables (AR) entry will also save considerable time.
and complex error correction thus slowing down the AR process. Re-work of a claim typically accounts for the single most costly event of the billing process. The investment of a claim scrubbing product pays for itself in saved time and timely paid claims.

Continuously updating the claim scrubbing tool is also imperative. New rules must be put into this product immediately along with other carrier changes. The practice should also have the ability to write internal rules into the scrubber based on denial analysis and other internal practice rules to ensure all fields appropriately populated. Typically a certified coder would be tasked with the accountability for this product and maintenance.

### #5 - CLEARING HOUSE/ELECTRONIC FILING

After the charge has been “scrubbed” and is eligible for first time payment, electronic filing of claims through a clearing house should be scheduled multiple times a week. Larger practices may want to file daily. The clearing house typically supplies the practice with reports detailing the claims that filed to carriers and claims that failed the clearing house edits. Claims that did not pass clearing house rules must be addressed immediately for timely filing and payment of claim. Often these reports will also show trends to the practice that they can quickly react to and take corrective action. A person designated to “look” at these reports must be assigned after each insurance run.

### #6 - PAYMENT/DENIAL POSTING

As the explanation of benefits (EOB) and payments come back electronically from carriers and payers, prompt posting into the practice management system is the next crucial step in the successful billing process. Electronic remittance will contribute to the process with prompt and accurate posting of monies received. As each payer has unique remark codes explaining payments/denials, care must be given to correct interpretation of these codes. These codes can then be extracted from the management system and grouped for billers to work. From prompt posting, claims can be followed up, secondary claims filed, or patient balance billed.
#7 - FOLLOW-UP OF FIRST TIME DENIALS

Knowledge of how your practice management system handles various scenarios in the life of a claim is critical. Often times, options that may help the practice to automate this process are not turned on resulting in manual effort and over-looked claims. Someone must “own” the system and continuously communicate to the management team enhancements to the software that make this process more efficient and cost effective.

Having the ability to know which claims are outstanding will allow quick follow-up by billing experts. The ability to produce workable reports for staff is critical in staying on top of outstanding AR, thus reducing the aging of those accounts. The process for whom and when follow-up tasks are performed must be clear. This process should also be monitored (preferably by the software) to ensure billing office staff continue to meet the expectation of the practice. A common denial by carriers is the need for additional information (i.e. documentation). By identifying codes that will typically be denied for this reason and determining a process to allow easy access to documentation, the staff will have the ability to promptly respond to each denial for prompt payment.

#8 - PRACTICE MANAGEMENT REPORTS

You are only as healthy, successful and financially secure as your reports tell you. Thus, analyzing “billing reports” is escalated into the strategically critical column on your monthly list of “must dos.” What is apparent to all practices is that MCR reimbursement is going down, operating costs continue to go up, and more compensation can only be achieved by more productivity. Practices with increased productivity have increased collections; increased collections translate to higher compensation.

Considering key performance indicators, whether looking at MGMA best practices or using some other source, the truth is “you can’t manage what you don’t measure.” The mantra of QIT remains valid. The goals of your practice may drive what key performance indicators are important to you. They will also serve to provide you with evidence based management decisions.

In any practice, however, three areas need to be measured: (1) revenue cycle (2) cost efficiency and (3) bottom line or net revenue per patient visit. Revenue cycle measures the ability of a practice to collect payment for services provided. So what reports are key to measuring revenue cycle? Four metrics accurately collected will provide you with the most critical functions of the revenue cycle:
1. Total AR (the volume of accounts that needs to be collected) higher is better.
2. AR greater than 120 days (the amount of aged AR and thus difficult to collect) lower is better.
3. AR days (the average amount of time to collect a charge) lower is better.
4. Net collection percentage (is the practice being paid appropriately/accurately) higher is better.

It is also important to consider that a number is just a number until compared to meaningful benchmarking data. (i.e. MGMA or other reputable benchmarking surveys). Comparing to practice historical data is also useful as it will provide you with trends of the practice. The true value of data is in how it is used to improve performance/productivity/processes. Data not used to improve/determine behavior of practice processes is wasted time and effort.

There are other working reports that the billing office must consider as well:
- underpayments by carriers - even small amounts can add up
- credit balances - most credit balances are posting errors, consistent follow-up will identify errors allowing corrective action to be taken
- small balance write offs - by looking at this option closely, you might find as did a recent practice, that it was writing off MCD co-pays not collected at front-end

These reports will provide additional data to the billing office to prevent unnecessary aging, allow collection of all the monies due by carriers and provide good customer service to the patients.

#9 - ACCURATE/TIMELY PATIENT BILLING

Nothing destroys patient satisfaction more than an inaccurate and difficult to read statement from the practice. Statements need to be sent to patients on a regular basis to keep them informed of the actions taking place on their account. Accuracy on the statement allows for payment of the balance that is now patient responsibility and reduces calls to the practice for further explanation of that statement.

Making the statement easy to read and understand using language the patient can comprehend is time well spent. While provider care is an indicator of patient satisfaction, how billing offices handle filing to insurances, producing a statement and giving multiple options for payment will also increase their satisfaction. Great performers take patient satisfaction seriously; from the time the patient calls for an appointment until they receive an accurate timely statement. Going forward, practices will need to spend more focus on front end collections. With high deductible plans, patients will be spending more and more out of pocket for health care. Practices must come up with a strategy to deal with this trend.
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would be well worth an investment in software that the front end can use to determine if a deductible is met, if a co-pay is due for visit and to collect. If you do not collect on front end, there needs to be a clear and aggressive policy for collection by statement. Patients should be prepared to make payment arrangements, give a credit card for a monthly payment, or have access to a financial counselor who can help them manage this cost.

#10 - LEVERAGE TECHNOLOGY

Technology has become ingrained in our daily lives. We have come to accept and learn new technology as a way of life. Patients have too, and their expectations of practices in the use of technology can greatly enhance the overall patient experience.

Some of the areas that a practice may want to explore are:

1. Practice web site - providing information about the practice to the patient.
2. On-line appointment scheduling.
4. On line forms for patient to print and complete prior to appointment.
5. On line payment options.
6. A face book page for patients to learn more about chronic illnesses, receive wellness tips, and other informative news for patients.
7. Email opportunities for patients with questions, record stats (i.e. BP/blood sugars, temps and other stats).
8. On-line statements with clear explanations.
9. iPads in exam rooms for EHR access.
10. Printers in exam rooms for providers to print off important information for patient.
11. Lab and x-ray results.
12. Custom working reports for business office to improve productivity.
Account + Ability = GREATNESS

The medical billing process is can be PUZZLING; however by incorporating these 10 strategies into your billing office and practice will lead to positive cash flow for the practice. This process must involve everyone from the patient to the physician. When everyone understands the expectations, success will be shared by all. Going from good to great and optimizing cash flow requires a full commitment of staff on a consistent basis. Making staff accountable for the areas of responsibility ensures the staff remains focused on goals. As a final thought, it is also important to have some fun with staff........show them you appreciate their hard work and dedication.

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