Seven revenue-driving best practices

1. Self-pay Collections
2. Measuring Performance
3. Claims Scrubbing
4. Track and Prevent Denials
5. Create and Enforce Write-off Policy
6. Remind Patients of Appointments
7. Maximize Electronic Remittance Advice

#1 in overall performance
from the 2014 Ambulatory RCM Services Report
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NEXTGEN® HEALTHCARE

Don’t just get by; thrive.

Today’s healthcare landscape of increased regulations and pay-for-performance models, combined with declining reimbursements, has made Revenue Cycle Management (RCM) critical for success. Fortunately, there are opportunities for practices to improve their revenue cycles, including:

Identify and fix revenue cycle leaks

Benchmark business achievements

Better manage daily, weekly, and monthly to-do lists for steady cash flow

From front-end operations to back-end processes, there are actions you can take to ensure you get every dollar you deserve. This eBook explores seven revenue-driving best practices that can help you excel.

Health costs continue to rise and employee contributions are increasing at a rapid pace. In fact, employee contributions have outpaced employer contributions by 6% over the last 5 years and deductibles have steadily increased. Providers, therefore, will need to respond with thoughtful strategies for self-pay receivables management.

CHAPTER

1

Self-Pay collections

Get more money faster: check eligibility.

About 60% of Americans get insurance through their employers. To cut costs, these employers are passing fees on to employee through increased co-pays, deductibles, co-insurances, and decreasing overall benefit coverage.[1]

With patient deductibles and co-insurance increasing each and every year patient collections can make or break the financial health of a practice. It all starts with checking a patient's eligibility. So use an eligibility tool to verify a patient's eligibility, plan specifics, and copays/deductibles.

It is important to check eligibility to:

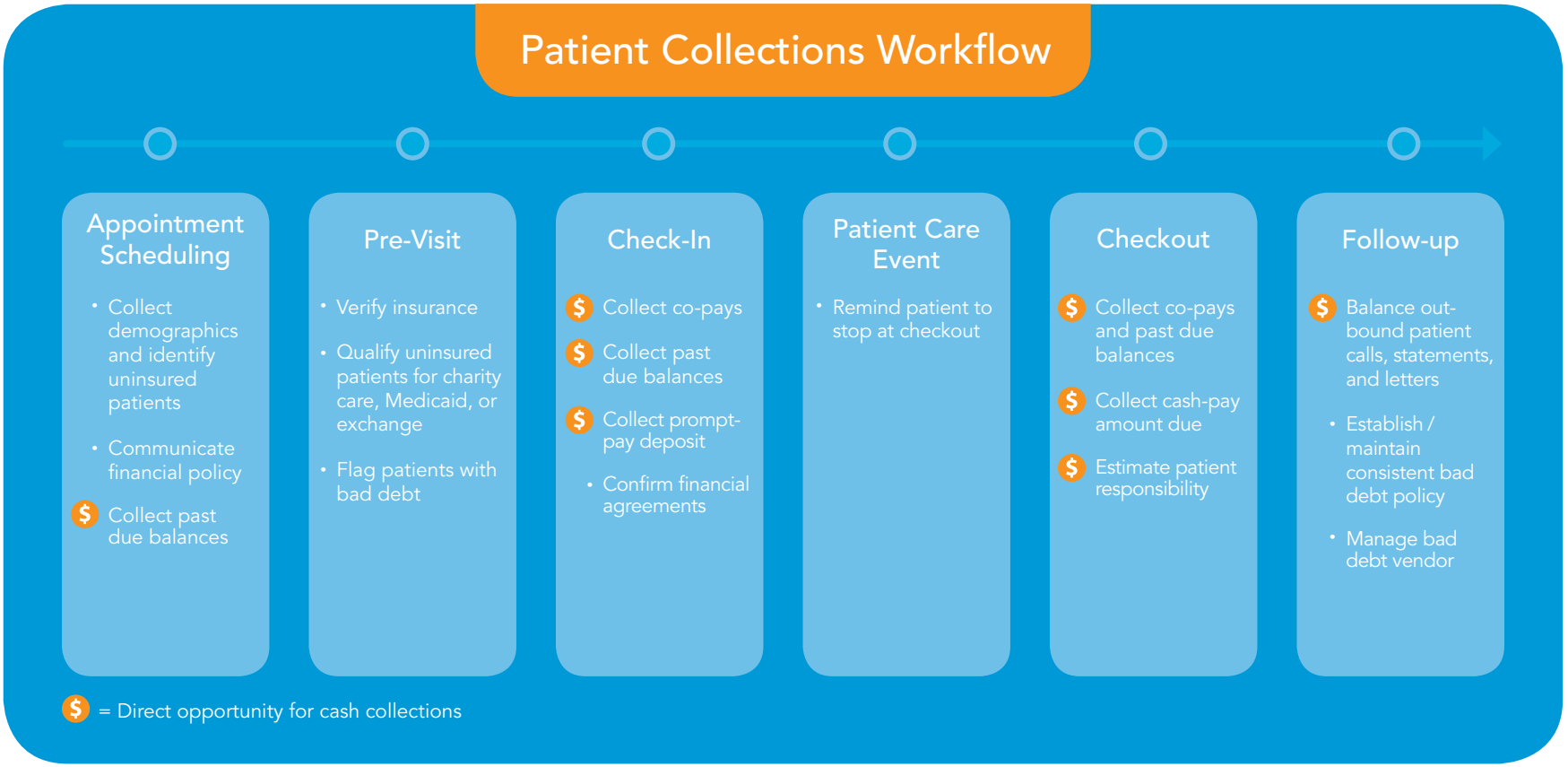
1. Obtain upfront collection of co-pays and deductibles
2. Eliminate claim denials, claim resubmittals, and unpaid patient balances in A/R

To ensure optimal self-pay collections (both true self-pay and self-pay after insurance), it is paramount to understand where and how you can affect performance.

[1] SOURCE: 2012 Survey of Employer Sponsored Health Benefits conducted by the Kaiser Family Foundation, NORC at the University of Chicago, and the Health Research and Educational Trust.

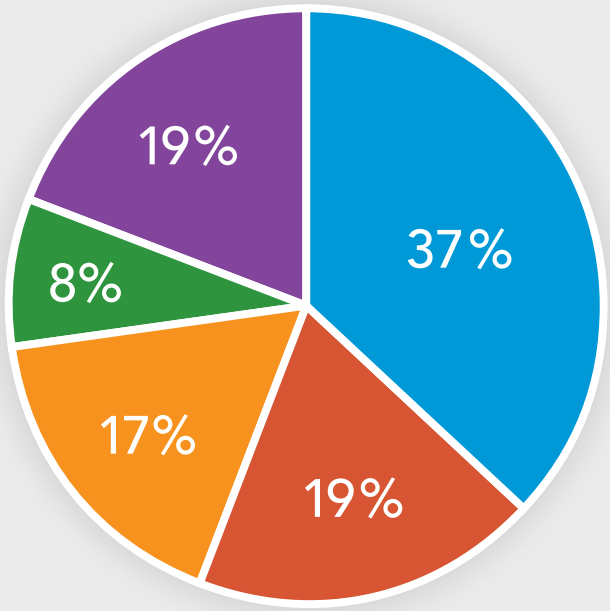
Self-Pay best practices you can execute today:

- Check to ensure patient does not have insurance
- Make sure office staff obtains accurate demographics data
- Provide front end staff with comprehensive training and distribute sample scripting to help staff feel more comfortable with point-of-service collections
- Look to implement some creative ways to collect patient payments other than traditional statements, including:
  - Kiosk technology
  - Patient Portal
  - E-statements
  - Stop seeing patients who owe money



Incentivize your patient and everyone wins.

Because patients pay their balances much more slowly than third-party insurers, providers should incentivize patients to resolve balances quickly. Offering financial incentives to resolve balances faster is mutually beneficial to both patient and provider. Lack of payment may not be due to a patient's inability to pay. Providers, therefore, should help patients resolve medical bills by offering more financing options. Many patients may want to settle their balances when given a payment plan.



Stated Reasons for Nonpayment, Percentage of Insured Respondents

- Lack of financing options
- I just received my statement
- I forgot to pay or was confused about what I owe
- Healthcare is a right, I shouldn't have to pay my bill
- Other

SOURCE: 2009 McKinsey Survey of Retail Health Care Consumers

CHAPTER

2

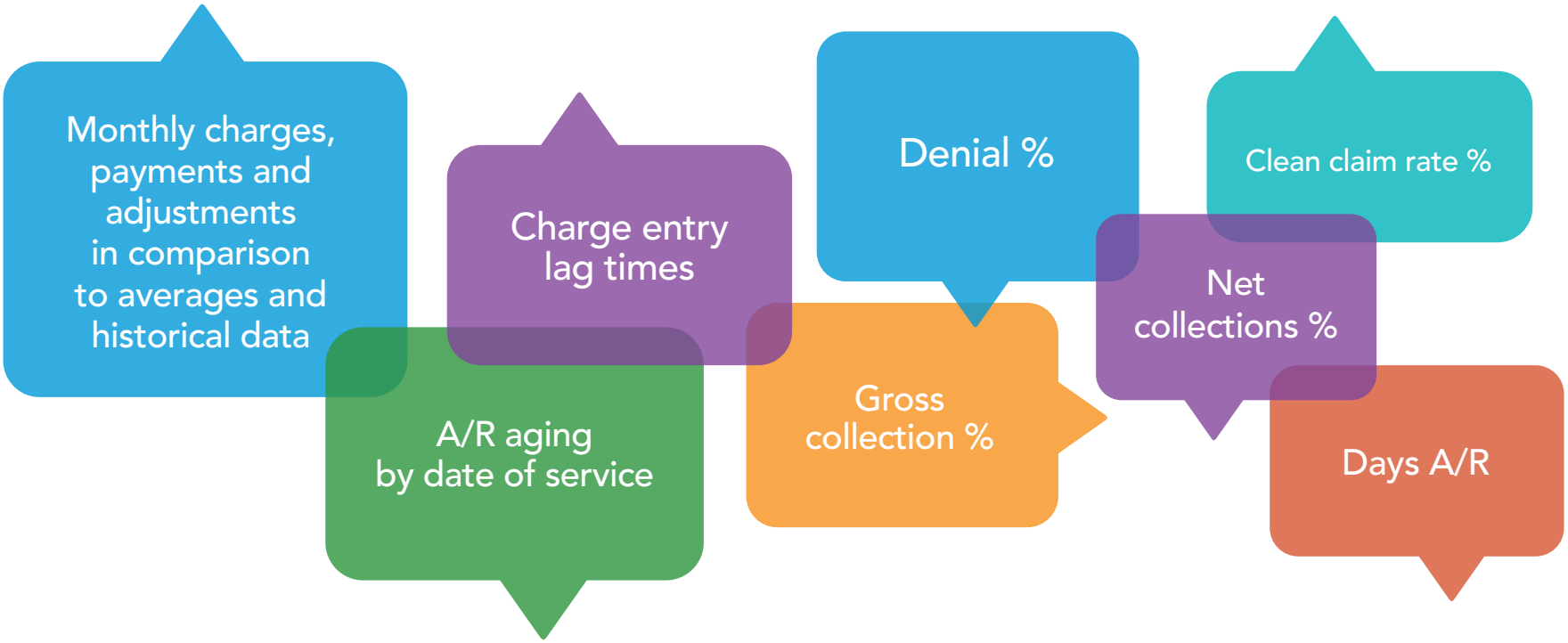
Measuring Performance

Knowledge is power: A/R transparency can transform your business.

Measuring and monitoring your revenue cycle allows you to compare key indicators of billing and collections performance from month-to-month and year-to-year, and to compare them to industry and specialty standards.

Analysis of key performance indicators can help you find opportunities to improve business performance and uncover problems with payers. We recommend establishing metrics that can be monitored and measured on a consistent basis, at minimum, every 30 days. By analyzing these metrics you get a clearer picture of how fast you are getting paid, who's not paying you, and why you're not getting paid. With that knowledge you can improve and streamline processes to ensure a healthy A/R.

Key revenue cycle performance indicators that can help you benchmark and achieve your best practice objectives:



Calculating revenue cycle metrics.

A key benchmark for success is your A/R days. This is an important revenue cycle metric because it tells you the number of days that money owed to you remains unpaid. It is not difficult to calculate A/R days. First, to properly account for volume, the calculation for days in A/R should be: total current receivables after credits divided by average daily charge amount.

Important A/R formulas

Net A/R = Ending A/R – Bad Debt A/R – Unapplied

Charges Per Day = Charges/Days In Month

Payments Per Day = Payments/Days In Month

Gross Collection % = (Payments/Charges) *-1

Adjusted Collection % = Payments/(Charges + Adjustments) *-1

Know your charge lag and processing time.

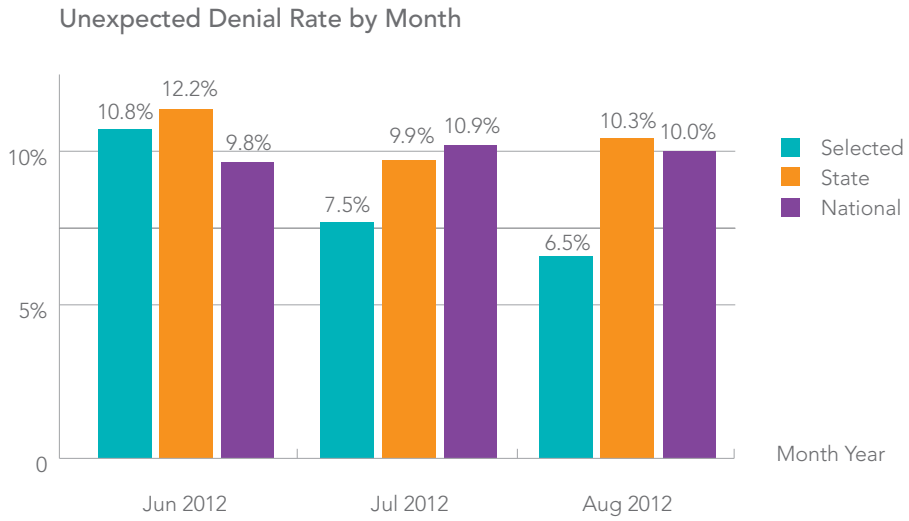
The time between the date of service and the date the charge is entered is lag time. How long is yours? Since a large part of managing the revenue cycle is the measurement of days in A/R, a significant lag in the time it takes to get claims submitted to payers can negatively impact the A/R days metric.

Processing time is also important. The time between the date of service and the date the payer writes a check for the claim is your processing time. Payer processing time is the number of days from the date of payer receipt to the check date of a claim.

Compare gross and net collection ratios.

The gross collection ratio shows how much of what you bill for you actually receive. When you compare your gross collections ratio with your net collections ratio it can help determine whether your fees are less than what the payer allows. You could be collecting less than what you charge due to contractual adjustments, making it more important than ever to actually collect all of what you are entitled to receive. Having complete visibility into whether or not you are indeed collecting every penny due will show you where you are leaving money on the table.

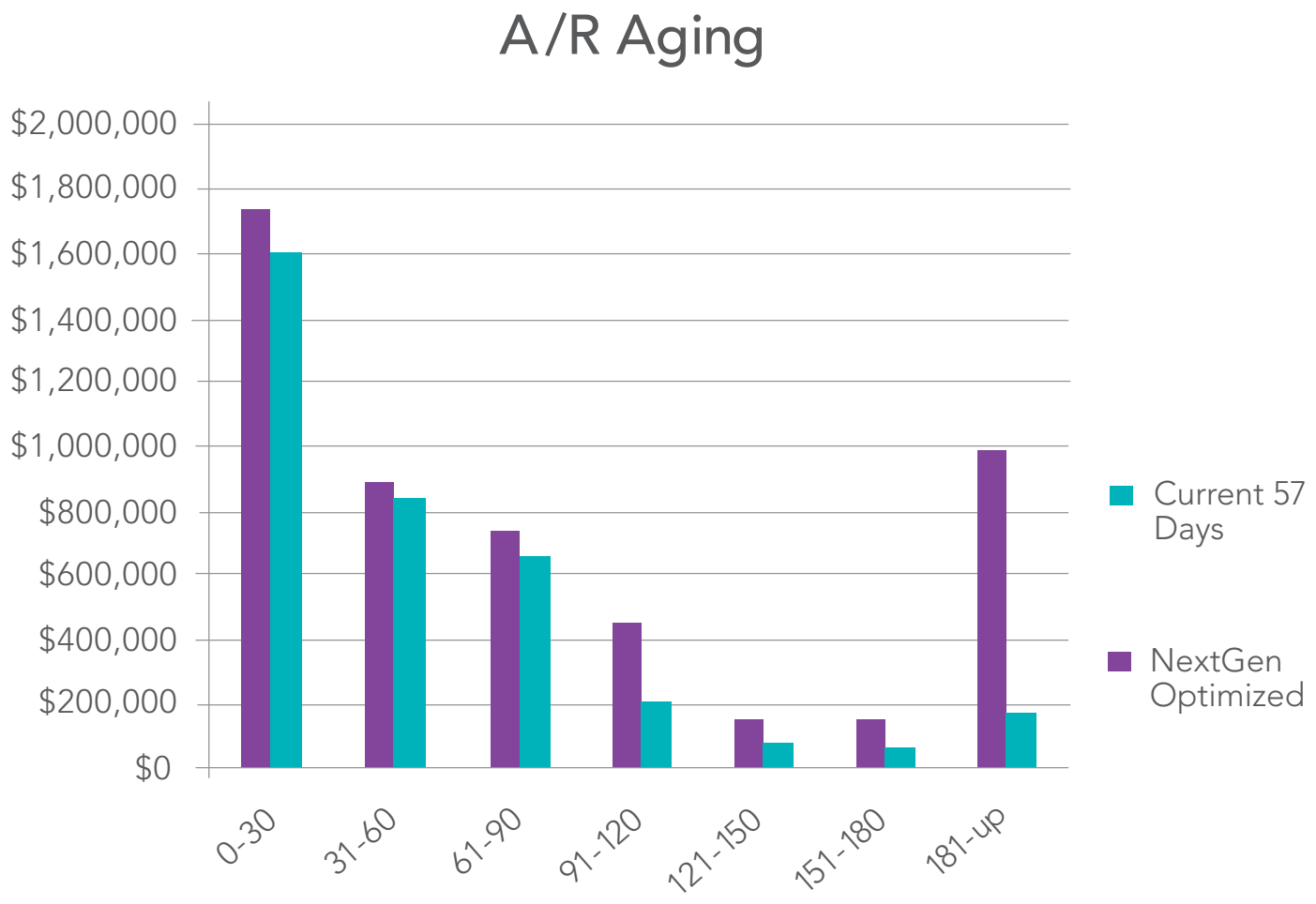
A sample 90-day assessment and comparison of a practice's Electronic Remittance Advice to peer practices.



Is your debt aging well?

Everyone wants to get paid faster. A good aging analysis will show you exactly how well your billing staff does the follow-up on patient accounts and insurance claims. These reports show you how long it's taking for your claims to be paid—30, 60, 90, 120 days, or more.

This graph is an example of A/R aging for a practice, showing current A/R by aging category, compared to an optimized A/R management from NextGen® Revenue Cycle Management, (NextGen® RCM) which is closer to 35 days in A/R.



Diagnosing your A/R health.

The first-pass clean claim rate, or the rate of first-pass claim acceptance at a clearinghouse, is an indicator of how often claims are being sent out correctly the first time. The standard best practice clean claim rate is 80%. NextGen Healthcare clients, however, enjoy an average 95% first-pass clean claims rate.

The denial rate is also an indicator for a healthy A/R. It's the percentage of claims denied by payers. Average denial rates vary by specialty, but for most practices, a denial rate of greater than 10% is considered poor. Performance measured by denial rate is influenced by your payer mix and specialty and the level of automation that is deployed.

Your clearinghouse or a billing and collections provider such as NextGen RCM Services can help conduct a more in-depth denial rate analysis by payer, provider, remark code, and category to gain an even better sense of the factors influencing your denial rate.

Automated processes can help ensure your practice has lower denial rates, and thus, improved cash flow.

CHAPTER 3

Claims scrubbing

Use best practices for cleaner claims and appeals.

Even experienced billers can miss errors when reviewing claims manually. Implementing "claim scrubbing" software, which identifies and fixes problem claims automatically, can save billers time, ensure greater accuracy, and generate faster error resolution.

Another best practice is to monitor the process and ensure the workflow is being followed and errors are being resolved in a timely manner. A good claim scrubber system can significantly reduce denials. For example, a NextGen RCM Services client can expect a 3-4% reduction in denials from claims submitted through their services. That result leads to accelerated and increased revenue for you.

Be sure to appeal denied claims. According to MGMA, only 35% of providers do. Inspect your denied claims. Ensure they are correct and develop a denial management process in your practice.

Task an employee with appeal duties. Otherwise, you could be letting more than 4% of what you're owed slip through the cracks!

Best Practices

- Claims scrubbing technology to reduce rejections and denials
- Create a library of system edits to improve "first-pass" claims success
- Load CCI edits – Appropriate CPT and diagnosis combinations
- Use advanced scrubbing with a payer rules engine specifying codes and modifiers for each payer
- EMR (electronic medical records) integrated with billing
- Ensure all payer required fields are completed
    - Member ID number
    - Date of Birth
    - Rendering and referring provider
    - Authorizations
- Leverage online reporting and analytics reporting and analytics
- Contract compliance software that catches and corrects frequent underpayments by payers

CHAPTER 4

Track and prevent denials

Capture, analyze, and act on denial data.

Effective denials management is about being proactive and diligent. Engaging in eligibility verification prior to a patient's visit is one front-end strategy to reduce denials. On the back-end, develop a routine system for denials monitoring. Typically, 85 to 95 percent of claims either get paid on the first pass or prompt an action to redirect the collection to a secondary payer or the patient. The remaining five to 15 percent of claims present a real opportunity to improve the revenue cycle.

It is important to regularly review what carriers, CPTs, reasons, and processes are driving your denials. It's also important to identify areas where your revenue cycle management staff may be performing redundant tasks. Review real examples of denial analysis and interventions to understand the types of edits and approaches that will help you build an experience library. This library can be used to learn from your denials and prevent them from happening again.

Denials management is not a "once-and-done" effort. It must be ingrained in daily, weekly and monthly workflow. Capture, analyze, and act on denial information.

The goal, here, is to eliminate the root cause of denials through improved workflow and technology, resulting in optimized revenue and minimized re-work. Additional recommendations for tracking and preventing denials:

- Create a mechanism to trap denials from all sources of remits including 835 files as well as manual remits
- Organize denials into categories such as:
    - Eligibility
    - Coding
    - Non-covered services
    - Authorization/Referrals
- Analyze patterns and create alternative work-flows to reduce denials
- Consider bulk eligibility verification

Payer reasons for denying claims:

- Not verifying a patient's insurance coverage
- Entering incorrect information for the provider (name, address, contact information, etc.)
- Entering incorrect information for the patient (name, sex, date of birth, insurance ID information, etc.)
- Entering incorrect information for the insurance provider (policy numbers, address, contact information, etc.)
- Insufficient ICD-9 codes / effective 2015 ICD-10 Codes
- Inputting mismatched treatment and diagnostic codes
- Forgetting to input codes at all for services performed by a physician or another healthcare official
- Undercoding
- Duplicate billing
- Staff performing the service was not credentialed
- Missing (required) supplemental attachments or incomplete documentation for services provided
- Issues around general knowledge and use of modifiers causes issues

CHAPTER

5

Create and enforce write-off policies

The right approach to write-offs.

A write-off is an amount that a practice deducts from a charge and does not expect to collect. Successful practices have established sound policies and procedures in place for "write-offs" and have a formal manual to ensure that they are taking advantage of all available ways to increase their bottom line. To stop providing free services to patients and leaving money on the table, providers and practices need to employ proactive financial policies that are shared with their patients and then enforce them.

Contractual write-off: part of a patient's bill that can't be charged due to payer agreements, including:

- Charity write-offs, the difference between the practice fee schedule and what's collected, may be in accordance with an indigent care effort, a policy adhered to in a faith-led healthcare system, or a financial assistance program
- Small balance write-offs, the amounts left on the patient's account that may not warrant the cost of sending a bill, which has been estimated to cost about $12.00 each
- Prompt payment discounts and self-pay (no insurance) discounts are write-offs for patients paying in full at time of service, or discounts given to patients without coverage

Necessary or Approved write-off: write-offs that you have agreed to, either in the context of a contract, or in terms of your practice philosophy.

Unnecessary write-offs: write-offs that, more often than not, can be avoided with timely filing of appeals. They are a result of billing mistakes or situations that you should have been able to control, including:

- Timely filing write-offs caused by filing the claim past the date required by the payer; make sure you know your timely filing limits for each payer
- Uncredentialed provider write-offs are those caused by filing a claim for a provider before they are credentialed with the payer
- Administrative write-offs are those approved by the practice based on service issues or practice error
- Bad debt write-offs are balances that you have decided to write-off and not pursue further

Collection agency write-offs: these balances are not forgiven but are written off the main A/R and transferred to a third-party collection agency to collect on your behalf.

Using credentialing services such as NextGen RCM Services is an easy way to prevent uncredentialed write-offs.

CHAPTER

6

Remind Patients of Appointments

Appointment reminders boost A/R.

Ensuring all appointment slots are filled and patients are confirmed is critical to financial success. Appointment no-shows impact your bottom line with staff time costs but can be reduced with an automated appointment confirmation system. HIPAA considers appointment reminders as a part of treatment. They can be made without an authorization, but require you to do what you can to accommodate a patient's preferred method of communication. You can remind patients by mail, email, text, and/or phone.

In most practice management (PM) systems, this is an easy task. Most dialing systems can accept your appointment schedule from existing reports already contained in your PM system.

NextGen® Electronic Data Interchange (NextGen® EDI) downloads your appointment schedule from your NextGen® Practice Management system and contacts all scheduled patients using automated reminders, allowing you to select from a variety of standard messages or create your own. You can also choose how far in advance your patients are contacted. NextGen EDI confirmation reports are issued automatically and include the number of busy signals, confirmed appointments, requested reschedules, and failed attempts.

Monitor for success.

Track and document your cancellations and no-shows to find where improvements can be made to increase your kept appointments rate. Adjust parameters such as how far in advance your patients are contacted to see what works best.

Final recommendations:

- If not already in place, implement a policy for No Show and/or Late Cancellation Charge(s) to attempt to recoup lost revenue
- Having staff contact patients in advance of appointment is great but not efficient and it is costly so look to increase staff productivity while decreasing cost by implementing a Third Party Appointment Reminder product
- At a minimum, patient should validate
    - Date and time
    - Location
    - Copay amount

CHAPTER 7

Maximize Electronic Remittance Advice

Make the most of "ERAs".

To expedite cash-flow and payment posting mistakes sign up for Electronic Remittance Advices (ERAs) today. Electronic claim submission maximizes claims processing efficiency. Paper submissions do not. About 99% of payers accept electronic claims, and Medicare requires them. It takes an average of two weeks to receive reimbursement for an electronic claim if you establish an ERA, and six to eight weeks for a paper one. According to the American Medical Association (AMA), the average cost of processing a clean paper claim is $6.63. The same claim sent electronically costs only $2.90.

Successful electronic claims helps optimize revenue cycles in practices by streamlining the billing process and reducing paperwork. With electronic remittance your clean claim rates and turn-around times will improve, getting you paid faster.

Vendors like NextGen Healthcare can help you implement automated practice management tools and set up auto-posting of your remittance information back into your billing system, using technology to automate time-consuming routine jobs. This frees your staff to handle other assignments or focus more on care.

Automate routine tasks using Practice Management.

Best Practices

- Set the Background Business Processor to bill encounters nightly
- Set the Background Business Processor to create your EDI files nightly
- Set the Background Business Processor to print paper claims daily or have your claim clearinghouse print HCFAS
- For unique claim situations, make sure you are using the claim print libraries
- Set the Background Business Processor to create your statement file as needed: weekly, monthly, or daily

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