7 Best Practices For Revenue Cycle Management

Revenue Cycle Management Solutions

In healthcare, revenue cycle management (RCM) is the process used to track and collect revenue from patients. RCM begins with scheduling a patient for a clinical encounter through the final payment for the healthcare services rendered. The Healthcare Financial Management Association (HFMA) defines the revenue cycle as "All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue". Applying best practices to the revenue cycle ensures the maximum reimbursement for services.

The revenue cycle begins when a patient is scheduled for a clinical service. Patient payer data is collected which is utilized to verify the patient's identity and assign a payer source. Registration follows, with a review and authorization of compliance documents and patient deductibles are collected. During the patient's clinical encounter, clinicians document the services they render and the supplies they use. This documentation is then used for charge capture and code assignment for billing the patient's insurance. After patient discharge, all the data from the encounter is collected and fed into the billing system where a claim is submitted to the patient's insurance carrier. When the claim is reimbursed and all patient deductibles and charges have been collected – or deemed uncollectable – the revenue cycle is complete.

Medicare and Medicaid funding cuts, shrinking reimbursement rates, and increasingly higher patient deductibles challenge healthcare practices and hospitals to search for ways to maximize revenue for their organizations. But many leaders are not even aware of how much revenue they're leaving on the table with inefficient revenue cycle management. Implementing best practices for RCM or outsourcing it to a 3rd party can substantially improve cash flow and revenue.

Best Practices to Improve RCM

1. Put the patient at the center of the process

Healthcare practices that maximize their RCM recognize the need for better patient relationship management. If the staff works proactively to improve patient satisfaction and build a positive relationship, the practice builds loyalty with the patient. Staff should provide both verbal and written explanations to the patient regarding their financial responsibility, payment options, and what to expect from their visit. Many patients perceive the medical billing process as confusing, intimidating, and frustrating and the more interaction they have with the staff on this, the more likely they'll be to reimburse the provider.

2. Invest in technology

It may seem like Medicare and Medicaid automatically deny every claim you submit. This may not be far from the truth if you haven't invested in technology to keep you up to date with diagnostic codes and payer requirements. And when you do get reimbursed, you may find that it's for less than you submitted.

It costs time to investigate unpaid claims, correct mistakes and resubmit them. It's even costlier if your practice is subject to a TPE from Medicare. Automated software systems can streamline prior authorizations, eligibility, medical coding, and billing and alert you to errors that need to be resolved before claims are submitted. Up to date technology with automation not only cuts down on the amount of time staff devotes to resolving unpaid claims but gets your reimbursements faster.

Minimizing denied claims begins with the front office, but the entire staff should be educated as to what is required for an approved claim.

3. Collect patient financial responsibility before services are rendered.

Healthcare revenue cycles slow or come to a halt when patient financial responsibility is late or underpaid. Healthcare practices and hospitals run the risk of never receiving full payment for services and additional staff must be employed to follow up with patients and collect. Unfortunately, more than half of patients with outstanding medical debt never pay it, and with high deductible insurance plans as the norm, this won't change anytime soon.

Optimize patient collections by collecting deductibles or presenting payment plan options before services are rendered.

4. Automate prior authorizations and eligibility

Verifying insurance coverage during patient registration is the first step in successful RCM.

Increasingly, insurance companies are creating stricter requirements for prior authorization and coverage eligibility. This rise in requirements necessarily slows reimbursement and can result in many more denied claims. Automating prior authorizations and eligibility can help optimize clinical processes, speed the revenue cycle, and reduce time spent on this task for front office staff.

5. Improve charge capture and coding

It's important for hospitals and healthcare practices to develop and implement processes to efficiently capture revenues for services rendered. Common areas that experience lost revenue are outpatient nursing procedures like IV therapy and injections due to a lack of proper nursing documentation. Pharmacy revenue is lost by missing charges or errors in reporting of units.

Nursing and pharmacy teams should review charts and claims for missed charges; submit proper nursing documentation with start and stop times, sites, and drugs, and regularly review pharmacy charges to determine the appropriate reporting of pharmacy dispensing units.

6. Timely filing of claims

Many healthcare organizations don't file claims in a timely manner and miss filing deadlines. Medicare allows one year for filing of claims from the date of service, but many private insurance companies only allow 90 days. If deadlines aren't met, claims go unpaid and the practice must write-off clinical services. It's important to have processes in place to make sure these deadlines are met.

7. Denial Management

All the above best practices, when not followed, may result in denied claims. Monitoring and tracking denials is critical for any hospital or medical practice to identify trends and discover their root causes. A denials prevention program should be implemented for the entire staff that focuses on standardized processes to mitigate denials risk. Best practice denial management programs can reduce A/R, increase cash flow, decrease denials volume, and lower cost to collect rate.

Advantum Health brings automation and technology to your RCM. Contact us today to learn how we can speed your revenue cycle management.

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