How Do You Know if Your Revenue Cycle Management Team is Doing Their Job?

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Whether you have an internal revenue cycle management team, or you outsource these processes to a third party, it is vital that you are able to measure their performance. At Commonwealth Billing, I am often faced with questions related to collection reports, encounters summary reports, and payer reimbursement, but many providers ignore critical data that determines the overall health of your revenue cycle process. In this newsletter I reached out to a dear friend and mentor, Pat Smith, to help shed some guidance on specific metrics you should be analyzing in your current revenue cycle process.

According to Pat, **the first step any provider should take is to review all claims that are in accounts receivable (A/R) over 45 days**. As I personally tell new clients, many billers will simply submit claims and see what comes in. The difficult part in medical billing is working the difficult A/R that lingers past 45 days. Pat recommends providers have their billers check on these claims and continue to call weekly until the claim is paid. Each phone call or effort to collect on claims needs to be documented within your practice management system so they are traceable and verified. In Pat's words, "if it's not noted, it didn't happen."

Additionally, Pat encourages providers to run A/R aging each month and to stay focused on claims that are out over 45 days. At MD Billing, Pat requires each account to have no more than 18% of the provider's total A/R out over 45 days for primary insurance. For secondary insurance, she requires each account have no more than 25% of the provider's total A/R out over 45 days. By keeping a watchful eye on A/R over 45 days, billers can head off and work most rejection and denials to minimize write-offs. This process also helps billers identify common denial or rejection reasons, which we will discuss more below.

Pat pushes clients to take a deeper dive into their electronic claims. She stresses the importance of having billers follow up, review remittances, and work denials for all electronically submitted claims. This process includes going line-by-line in each claim to make sure each claim was paid correctly for all CPT codes. If only four out of five CPT codes have been paid billers need to work the unpaid CPT codes to make sure they get paid as well. Here at Commonwealth Billing, we have our billers check electronic remittances at the start of each day.

Another denial-based suggestion Pat gives clients is to watch the local coverage determination (LCD) denials. If practices are encountering these rejections the physician will need to go back to review the patient's chart to make sure the correct diagnosis codes were used for the services rendered. According to Pat,

"Practices are going to start getting dinged for unnecessary testing if they do not utilize the correct diagnosis codes." To avoid this issue, each practice needs to make sure their billing staff is notifying them of any LCD denials, and they are not only being corrected on an individual basis, but a process is put in place to prevent future LCD denials.

Finally, Pat conveyed that **the most important shortfalls she has encountered during her years conducting practice assessments stem from poor follow up and billers failing to adequately work denials**. Like I stated above, it is easy to simply click a button to submit a bill to an insurance carrier, but determining whether a billing company is worth its wait boils down to their ability to collect on denied and difficult claims. According to Pat , "If your billers are not filing corrected claims and appeals, they are not doing their job." The need to file corrected claims and appeals comes on a daily basis. If this is not what you are finding in your current billing department, it is likely these claims are being ignored or left unworked.

I would personally like to thank Pat for taking the time out of her busy schedule to speak with me and impart these priceless practice suggestions derived from her nearly 40 years in business. At Commonwealth Billing, I regularly consult with physicians and practices that have questions related to their current revenue cycle process. In most cases, physicians are concerned that A/R is not being adequately worked. Unfortunately, this is not uncommon in the revenue cycle management space and is absolutely critical to the financial viability and success of any practice. Hopefully, this newsletter provides useful advice to help you analyze how your revenue cycle team is performing.

If you have questions about your current billing process or concerns over unworked denials, feel free to give us a call today to see how we can help.

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[1] Pat is the founder and owner of MD Billing, LLC and its affiliate MD Consulting, LLC. Pat is very knowledgeable in all facets of medical practices and continually receives education in practice management, medical billing, and revenue cycle management. She has been in business since 1982 and has a successful track record setting up medical practices and managing practices. Her company now bills for more than 350 physicians and provides billing services for most specialties. She is pleased to have served some clients for over 35 years.