

Wise use of automation aids revenue cycle

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PROPERLY IMPLEMENTED, electronic practice management systems can significantly boost medical practice profitability. By integrating functions such as electronic medical records, accounting, online payment and e-mail, these systems can greatly enhance the efficiency and effectiveness of revenue cycle management.

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Billings increase as a result of fewer missed or undercoded services. Cash arrives quicker, thanks to electronic claims, and time-of-service collections enabled by real-time patient account balances. Electronic revenue cycle management also can dramatically cut billing staff time and errors, generating huge savings on overhead and claim denials.

But these automated systems are only as good as the information you give them. The basic processes remain the same – obtain correct patient information, capture and bill appropriate charges, collect payments, follow up unpaid balances, and review and monitor performance. As providers step into electronic revenue cycle management, success depends on how effectively providers integrate and maintain the following basic processes within an automated workflow.

Pre-appointment

Collecting accurate patient information is where it all starts. Without it, billing and collection problems are certain. Emphasizing the importance of this patient registration function during staff training – and reinforcing it on the job – will pay off handsomely.

Before scheduling an appointment, a provider office should ask the patient whether they're a new or established patient; the reason for visit; referral information; insurance coverages; and demographic information, such as name, address, daytime telephone number, employer and other such information. This is also the perfect time to explain practice financial policies, including payment of outstanding balances and payment at the time of service.

Before the appointment, an office needs to verify patients' insurance coverage by phone, fax or online. It also should check covered services; co-payment, co-insurance or deductibles due; and preapproval requirements.

Appointment

When the patient arrives, the office can take several steps to facilitate the automated revenue cycle process. It should confirm demographic and insurance information; copy or scan the patient's driver's license or ID card, and insurance cards; and collect co-pays, coinsurance, deductibles, and outstanding balances.

If information is not in the patient's chart, the patient should complete and sign forms for releasing information, HIPAA and financial responsibility.

Before patients leave, they should be asked for payment for the current visit and any outstanding balance. If patients are given an opportunity to pay in the office, there's an increased likelihood to settle their bills. After patients leave, collection chances plummet and follow-up expenses jump.

Listing patient balances on the encounter form (charge ticket) or the electronic practice management system facilitates in-office collections. To maximize effectiveness, encounter forms should be regularly reviewed and updated to ensure they are accurate and comprehensive. They should allow for out-of-office charges, such as nursing home visits. One advantage of integrated EMRs is they automatically document services and generate charges during patient visits.

Offering several payment options increases time-of-service collections. These can include cash, check, credit/debit cards, payment plans, postage-paid envelopes and on-line. Training staff in proper techniques for asking for payment and providing scripts improves both collections, and patient and public relations.

Post-appointment

Before submitting charges, perform a pre-billing review. Make sure encounter form information is accurate and that it supports CPT, ICD-9 or other codes, modifiers or descriptions, and that it complies with bundling and other billing rules. Many online products and electronic practice management systems offer scrubbers or claims editors that do this automatically.

Practices should strive to submit claims electronically daily, or even in real-time if available. Depending on the practice and billing system, a clearinghouse may be best. However, many commercial and government payers accept direct electronic claims.

A practice should strive to respond to claims edits as soon as possible; edits should be checked carefully and corrected immediately. Payers should be asked to notify practices of routine claim errors, such as no authorization, incorrect patient demographic or ID numbers, and others, within 10 to 13 days after a claim is submitted. Practices should use online pre-submission screens if available.

When payments are received, they should be deposited daily along with other funds received. Many banks offer a lock box option, which can give practices credit for deposits quicker. Payments should be posted to insurance and patient accounts immediately, which helps practices keep up to date on accounts requiring follow-up. Payer explanation of benefit statements should be used to ensure accurate posting.

Providers should accept electronic remittance from payers if possible; however, the process should be audited for accuracy and timeliness. Practices also should follow up early and be proactive in collecting payer and patient balances, using practice management and billing reports to pinpoint aging accounts, high/low dollar outstanding amounts, credit balances, unidentified accounts and so on.

With payers, practices should review claims status online; process and work payer denials, rejections and requests for additional information within 36 to 48 hours of receipt; audit payer payments against amounts specified in contracts; cultivate relationships with payer representatives to assist with payments; and establish regular in-person meetings with top payers.

In dealing with patients, practices generally should aim to generate statements on a schedule; ensure statements are understandable, showing balance forward, open items, insurance balances, patient balances and credit/\$0 balance; provide instructions for payment through credit or debit card, a payment plan option or on-line; and explain the practice's policy on delinquency notices, final statement and use of collection agencies.

Successful revenue cycle management requires monitoring, both retrospectively and through concurrent review. Practice management or billing system reports can be used to create a 13-month trend analysis to benchmark practice performance against industry standards, and as a teaching tool for practice education. Likewise, a dashboard report summarizing data creates opportunities for improvement, celebration and challenge.

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