COVER STORY

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6 essential elements for physician revenue cycle management

Physician billing operations should not be an afterthought for hospitals and health systems acquiring a physician practice.

The recent frenzy of physician practice acquisitions has created a sense of urgency for hospitals and health systems to complete these transactions quickly to remain competitive. As a result, these organizations have often focused their initial attention on negotiating contract terms, drafting legal documents, conducting asset appraisals, and assigning vendor contracts while deferring considerations on how to manage the revenue cycle aspects of physician practices.

Organizations that do not engage in thoughtful preliminary planning regarding revenue cycle operating standards for physician practices, however, can find themselves with a mixed bag of acquired practices that are both difficult to manage and unprofitable. In particular, inadequate planning and preparation can lead to poor performance in physician billing operations, as reflected in cash collections that are lower than desired, high accounts receivable balances, frequent write-offs, and patient and physician dissatisfaction. Such performance can necessitate major investments to right the physician revenue cycle ship.

Hospitals and health systems should take key action steps in the early stages of building a physician enterprise to ensure six essential elements of a well-run professional fee billing operation are securely in place.

Element No. 1: Capable Management

As a health system's physician enterprise expands to include more practices across a variety of specialties and locations, the complexity of the billing operation increases significantly. This environment, in turn, requires a revenue cycle director with a level of management skill and

AT A GLANCE

To be effective, a professional fee billing operation requires the following elements:

- Capable management
- An appropriate organizational model
- Consolidated practice management systems
- Transparency, standards, and controls
- An appropriate coding and compliance model
- ICD-10 preparedness

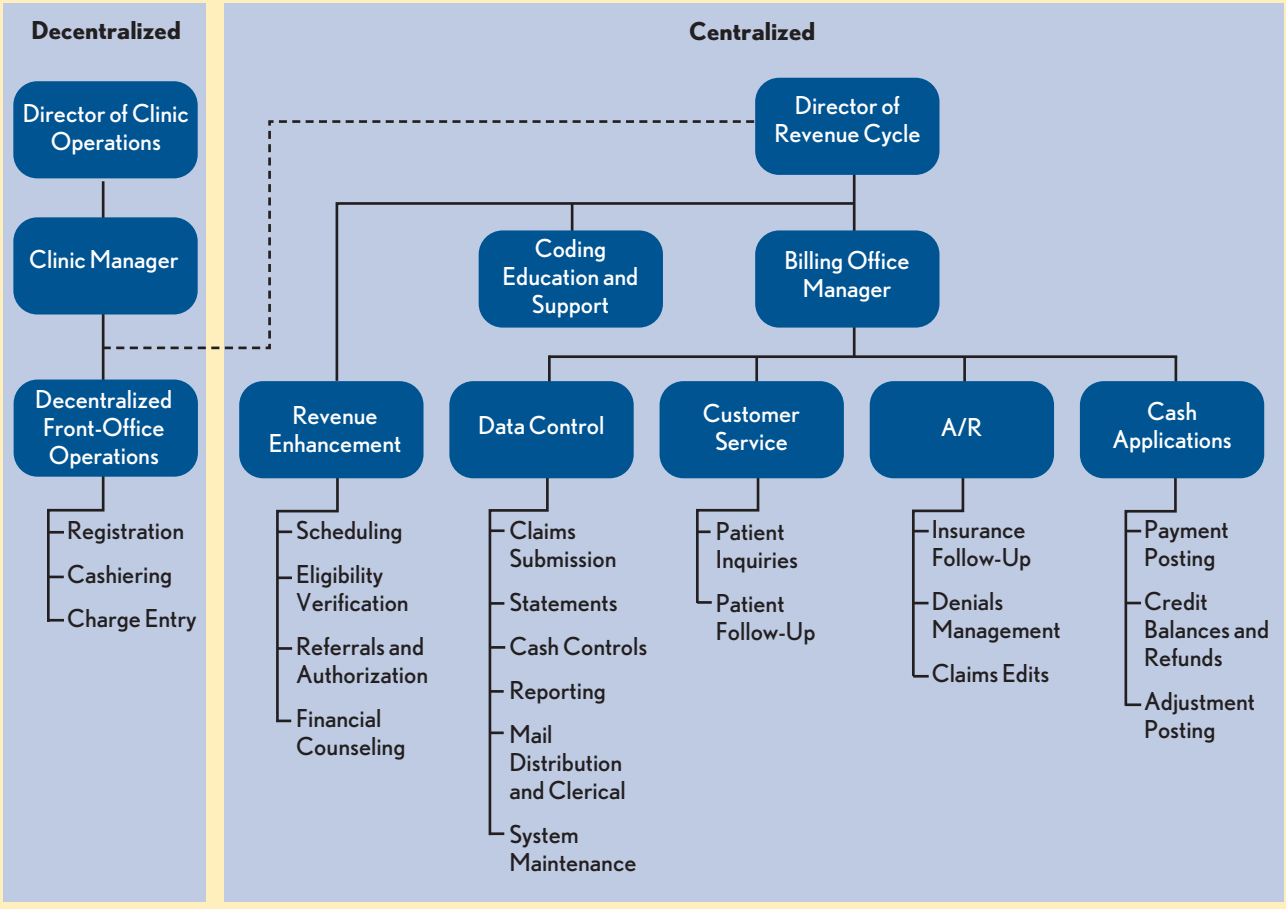
sophistication typically not found in smaller, independent physician practices, where billing managers (assuming a dedicated billing manager even exists) may have little or no formal training or experience in larger organizations.

In an era of reform, several areas related to physician revenue cycle operations require new skills. For example, a health system's physician practice revenue cycle director should be able to:

> Ensure appropriate visibility of front-end processes that have an impact on the revenue cycle, such as patient registration and insurance verification, through the use of relevant operational performance metrics
> Establish and enforce performance and productivity standards for billing functions such as coding, charge entry, insurance follow-up, and payment posting
> Provide input on decisions regarding IT system selection and configuration
> Analyze data to identify, diagnose, and resolve billing issues expeditiously
> Exercise appropriate influence on matters pertaining to revenue cycle processes and procedures not only within the billing office, but also across a large and sometimes bureaucratic organization

The person who performs these duties should be much more than an effective manager of the physician billing shop; he or she should be a leader whose opinion is sought and respected by physicians, peers, and executives. Without effective leadership from the revenue cycle director, it will be much more difficult to establish any of the other essential elements described herein.

SUGGESTED DELINEATION OF REVENUE CYCLE RESPONSIBILITIES



Unfortunately, revenue cycle management is often a thankless role with an unclear career path and therefore does not always attract top talent. Consequently, as physician practices are rapidly consolidated under hospital or health system ownership, the demand for people with the requisite skills is almost certain to exceed the supply, and it will be common to find revenue cycle managers (and even directors) who struggle to see the way forward for their operation.

Element No. 2: An Appropriate Organizational Model

In an effective revenue cycle operation, activities are organized in a way that ensures the right skills are available where they are needed while allowing for effective oversight. Among the most important decisions are those addressing questions of centralization versus decentralization and insourcing versus outsourcing.

Centralization versus decentralization. If the acquisition is an early one and the hospital has never handled professional fee billing for physicians, decentralized billing operations—in which the practice sites continue with their legacy billing systems under a single tax ID—may be appropriate. Decentralized billing also may be warranted, at least in the near term, when the organization takes on a practice whose billers have specialty-specific expertise that does not exist elsewhere in the organization.

However, as the organization grows, so does the need for a centralized and functionally organized billing office to ensure each task is addressed and economies of scale are achieved. A centralized approach can promote increased expertise within the organization as a whole, reduce errors, provide flexibility for new payment methodologies, and minimize exposure to compliance issues.

Most organizations find success in deploying a hybrid strategy that leverages economies of scale while simultaneously locating functional responsibilities where they can be performed most efficiently, as is shown, for example, in the exhibit on page 2.

The rationale for a hybrid model is that revenue cycle performance typically improves when all billing functions follow common guiding principles, which is most easily accomplished when these functions and the staff who perform them are managed as part of a single team. In a hybrid model, functions that do not require face-to-face patient or physician interaction are centralized, while locally managed clinical support staff are still expected to adhere to common revenue cycle policy. This reporting relationship ensures that financial matters do not become a secondary priority, particularly among staff who have other patient-facing duties, such as check-in.

Hospital-based organizations are often tempted to centralize operations further by merging back-office functions for facility and professional fee billing operations. Although this type of consolidation can be accomplished successfully within the customer service and patient collections functions, consolidation beyond those functions should generally be avoided. Professional and hospital billing operations are in some ways similar, but they are sufficiently specialized that billing staff rarely have the skills required to perform both effectively. More important, due to its high-volume and low-dollar nature, professional fee billing would almost certainly take a backseat to hospital billing if the two operations are commingled.

Insourcing versus outsourcing. Healthcare organizations that outsource portions of their revenue cycle operations typically do so to access advanced practice management capabilities more quickly or more economically than they could if they developed the operations on their own. When deciding whether outsourcing the revenue cycle is appropriate, organizations should consider three factors:

- The current competence of staff in professional fee billing
- The adequacy of the current electronic health record (EHR) or billing system
- The ability of the current staff and systems to expand with the growth of the physician enterprise

If two or more of these factors display significant weaknesses that cannot be strengthened quickly, then outsourcing may be the best option. Health systems also would have good reason to consider outsourcing the revenue cycle if the current in-house costs are higher than benchmarks or if collections percentages have deteriorated.

Nonetheless, outsourced billing is by no means a panacea, and the buyer should proceed with caution when selecting a billing agency. One of the most common misperceptions about outsourcing the billing operation is that it provides a turnkey solution requiring little involvement from the clinic or health system staff. Although less hands-on involvement is needed when the billing operation is outsourced (e.g., for staff recruiting and training), the requirement does not go away altogether, and the relationship with the billing agency demands ongoing attention.

Moreover, most billing agencies are paid a percentage of collections—an approach that would appear to align incentives, but may not always work in practice. Because the billing company keeps only a small fraction of what it collects, claims that are difficult to collect are actually money losers for the billing company, so the company has an incentive to write them off rather than make an effort for a small and uncertain return. Given these considerations, no healthcare organization should outsource billing functions without first having negotiated a sound, performance-driven contract that holds the vendor accountable.

REVENUE CYCLE ACTIVITIES OCCURRING IN THE CLINIC

Function	Example Control
Registration and demographic verification	Last verification date
Eligibility verification*	Eligibility denials rate
Authorization verification*	Services authorized in advance of service date
Time-of-service collections	Copayment collections rate
Charity care and cash discounts	Audit process
Coding, charge capture, and charge submission	Charge lag

*Some organizations find efficiency in managing eligibility verification and the referral authorization process centrally. Nevertheless, even with a centralized team, front-desk staff are the last safety net to verify whether a patient is eligible for seeing the provider and should confirm whether these centralized activities have been completed.

Element No. 3: Consolidated Practice Management Systems

The impact that IT decisions can have on the revenue cycle is also important to consider. Allowing acquired practices to continue using their existing practice management systems may be necessary in the short term, but this situation can quickly go awry. Maintaining disparate systems challenges economies of scale and the ability to monitor performance across multiple practices and promptly identify problems in the revenue cycle. The most effective approach is to transition all acquired practices to a single practice management system that facilitates, provides, or enables the following:

- A consistent approach to primary work flows (e.g., registration and demographic collections, eligibility verification, A/R follow-up)
- Automation to facilitate the billing flow (e.g., electronic remittance posting, prioritized work queues)
- Management of all work flows at the site of service and remotely (e.g., centralized business office, scheduling call center)
- Submission and management of both CMS-1500 and UB-04 claims forms to accommodate provider-based billing
- The ability to monitor whether payments are in accordance with contract terms
- Integration with an EHR
- Easy segmentation of performance where multiple tax IDs are in use (e.g., charge and collections volumes, A/R), while still creating efficient work queues that enable staff to manage billing effectively

Maintaining a single system also enables an organization to efficiently navigate (or at least prepare for) the changing regulatory environment under the Affordable Care Act and other recent healthcare legislation. By contrast, implementing necessary regulatory changes across multiple platforms could pose a daunting challenge.

Element No. 4: Transparency, Standards, and Controls

A key advantage of a large coordinated revenue cycle model is that it enables the division of labor and specialization of skills to a degree that is not possible at a smaller scale. For organizations to realize this benefit, they must carefully manage productivity, backlogs, processing time, and error rates. This point is true not only for the billing office but also for the clinics themselves.

Clinics should be held responsible for certain tasks, such as those shown in the exhibit on page 4. Moreover, when possible, edits and denials related to front-office errors should be routed back to the clinic for resolution. Although this process may increase the lag time for correction, it ensures that the clinic staff know about their errors and resolve them, rather than becoming lax because "someone will fix it on the back end."

Similarly, appropriate standards and controls should be established for billing office staff. Establishing and enforcing productivity standards is among the most important management steps for physician billing office managers, yet it also is all too commonly overlooked. Standards are needed not only to ensure that workers are being fully engaged, but also to aid in personnel planning. Without productivity standards, there is no rational basis for determining how many staff members are needed and when to hire, other than a general notion that "everybody's really busy." Examples of controls that can be used in managing the back-end process are shown in the exhibit at right.

In general, it is best to implement two to four key control measures for each function. Because these controls are so data-driven, they require a fairly sophisticated reporting and analytical infrastructure. Unfortunately, most practice management systems still do not have robust reporting capabilities, necessitating the implementation of "bolt on" business intelligence tools or the extensive use of spreadsheets to manage data. This issue is further confounded if the practice uses multiple systems.

A major challenge in running an effective revenue cycle operation is in engaging leaders throughout the organization in their roles regarding the revenue cycle. This effort requires periodic management reviews whereby leaders can track revenue cycle performance and identify where errors are originating and what is being done about them. It also requires an effective reporting and analytical infrastructure to ensure that these review sessions are effective. The revenue cycle director's leadership in facilitating these sessions also is essential.

Element No. 5: An Appropriate Coding and Compliance Model

The professional fee coding process is no easy task: More than 7,500 CPT codes and 13,000 ICD 9 diagnosis codes are currently available, and myriad complex payer and regulatory guidelines must be followed. This complexity will only be exacerbated with the transition to ICD-10 in October 2014. Moreover, physician practices use a wide array of resources and processes to complete this work; some groups require physicians to select codes via an EHR or encounter form, while others use support staff to abstract directly from the medical record.

Each approach has its benefits and limitations. In short, the "tug-of-war" that occurs as a result of trying to maximize revenue without crossing any compliance boundaries—while simultaneously trying to manage overall billing costs—can be daunting. Finance leaders are familiar with many of the challenges, as inadequate attention to coding has always tended to have costly repercussions,

REVENUE CYCLE ACTIVITIES OCCURRING IN THE BILLING OFFICE

Function	Example Control*
Insurance follow-up	Days since last follow-up activity
Patient follow-up worker	Outbound call volume per day, by
Payment posting	Transactions posted per day, by worker
Refunds	Refunds processed per day, by worker
Customer service	Inbound call volume per day, by worker

*Quality audits are a necessary complement to work standards for ensuring that staff do not sacrifice accuracy or take process shortcuts in pursuit of volume goals. Accordingly, volume targets may need to be adjusted depending on the level of accuracy required or desired.

such as an increased billing lag and unnecessary denials. Yet new challenges have also been introduced with recent focus of the U.S. Office of Inspector General on evaluation and management coding, which signals the likelihood of greater scrutiny on physician billing in the ambulatory setting, thereby adding the high costs for audits and recoupment to the list.

Experience shows that better-performing organizations maintain coding programs that are designed to balance regulatory compliance with revenue maximization and take several key attributes into consideration, such as those shown in the exhibit below. In short, they make sure the documentation for each visit supports the coding submitted for payment.

Appropriate investment in coding and compliance (whether internally developed or outsourced) will ensure that the charge submission process is efficient, claims are billed and adjudicated appropriately, and risk and subsequent expense are mitigated. These enhancements also will improve patient and provider satisfaction.

Element No. 6: ICD-10 Preparedness

Oct. 1, 2014, marks the compliance date for ICD-10. Given that professional fee reimbursement tends to be driven by CPT codes rather than by diagnoses, many in the industry tend to underestimate the effect that ICD-10 will have on physician practices. However, accurate diagnosis coding is still a fundamental component of the physician billing process, and the transition to ICD-10 could significantly affect short- and long-term cash flow and overhead costs if not addressed appropriately.

The American Medical Association has voiced objections to the 2014 implementation date, based on estimates that implementing ICD-10 will cost physician practices up to $80,000 per physician.[a] Implementation costs include the cost of training, business process analysis, IT system upgrades, increased documentation, and cash flow disruption. Some considerations—such as whether a practice's IT systems, vendors, clearinghouse,

a. Bresnick, J., "AMA Continues Protest Against ICD-10 Implementation," *EHR Intelligence*, Nov. 14, 2012.

CODING AND COMPLIANCE CONSIDERATIONS

Attribute	Consideration
Consistent coding and compliance policies tailored to the practice	> Coding and compliance policies should be established based on payer- and specialty-specific guidelines. > A communication plan should be developed to inform providers and articulate the source and rationale for these policies. This transparency will ensure buy-in and support.
Proactive and reactive provider education	> A consistent and documented communication loop should be established between providers and coders, including real-time feedback regarding error trends and improvement opportunities. > Providers should receive coding education that is periodic (e.g., semiannual classroom education) and ongoing (e.g., tips/tricks) to better understand compliance expectations and opportunities to improve documentation to allow for optimal reimbursement.
Regular compliance audits	> Periodic audits should be conducted for each provider (or abstracting coder). > Providers performing below a predefined accuracy rate (e.g., 75 to 80 percent) should be coached and reaudited within a probationary period. > Audits should be rooted in compliance and not revenue maximization.
Qualified support staff	> Where possible, certified coders should be employed to assist with abstraction, review, education, and audit. However, certification does not mean expertise—coders should be appropriately evaluated and demonstrate experience in their assigned specialty. > Annual education should be provided for each team member. > Not all coders are created equal. Some are exceptionally skilled at abstracting chart notes into CPT/ICD-9 coding but lack appropriate communication skills, while others are more equipped to train/educate. > If certified coders or specialty-specific experts are not available, outsourcing should be considered.

and payers will be able to support ICD-10—are well understood by administrators. But it also is critical for administrators to acknowledge less obvious effects, such as the impact that increased documentation standards are likely to have on physician productivity, particularly at the outset, and the subsequent impact on revenue and physician compensation plans driven by volume metrics.

In short, key considerations for establishing an ICD-10 implementation plan include the following:

> Evaluating IT systems, interfaces, and vendors that currently use ICD-9 codes and developing a transition plan
> Strategizing on ways to improve data capture and how to use those data
> Assessing training needs and developing programs to support both the initial and any ongoing training.
> Managing expectations regarding productivity loss
> Appropriately budgeting for implementation resources, as well as the short- and long-term impacts on cash driven by reduced productivity and increased accounts receivable
> Potentially revising work flows and processes

Despite being given a three-year reprieve on implementation, many organizations—particularly small physician practices—have not made progress on their ICD-10 transition plans. There is no room for further delays: Preparing for the change to ICD-10 now is essential for creating a smooth transition.

A Critical Early Consideration

Health systems that acquire physician practices often underestimate not only the challenges of developing an effective professional fee revenue cycle process, but also the consequences of not doing it right. Developing an effective physician practice revenue cycle requires sophisticated leadership skills, including strategic vision, organizational design, management discipline, and infrastructure development. Most important, developing a smoothly functioning revenue cycle process can have a profoundly positive impact on the bottom line of the organization. It therefore is well worth the time and attention it requires—not just after a practice acquisition has been finalized, but from the very start of the process. ●

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