Revenue Cycle Roadmap

Prepare your practice for value-based success

By Sreeram Mantha
A modern medical practice has many moving pieces. Health IT adoption, clinical quality reporting, and the rise of consumerism in health care bring unprecedented levels of complexity to the practice setting. As the industry pivots to value-based care, many practice leadership teams are fighting to maintain independence as a profitable business amid rising costs and decreasing reimbursement rates.

How do practice leaders and administrators with limited time and resources implement a strategy to improve revenue cycle performance while continuing to deliver high-quality patient care?

For many practices, the day-to-day management of patient throughput leaves little time to stop and evaluate opportunities to bring efficiency to existing processes and procedures. However, investment in an honest internal review can have a major impact on your practice’s bottom line. Methodical analysis of current processes and how they work together illuminates cracks in handoffs that result in revenue leaks. Knowledge of key performance indicators (KPIs) enables administrative teams to make educated decisions on how to implement best practices—some of which may be new to the practice—that plug those leaks and pave the way for revenue cycle optimization.

**Stabilize and Optimize**

Stabilizing and optimizing revenue cycle processes to ensure the practice isn’t leaving money on the table is a fundamental yet often overlooked element of any practice strategy. By tracking meaningful performance metrics and using analytical tools to transform data into actionable information, your team can begin making strategic improvements to operational areas that will have the greatest positive impact on revenue and outcomes.

Start by taking a probing look at the foundation of existing billing operations. Weigh financial KPIs against established industry benchmarks to reveal underperformance in coding, claims filing, billing, and collections. Your goal is to keep KPIs on par with or better than industry standards. Executives should closely monitor the financial KPIs and their corresponding industry benchmarks as shown in Table 1.

Industry benchmarks enable peer comparison through quantitative, metric-driven performance tracking. This comparative analysis arms administrators with operational insight into areas most in need of attention to drive an informed improvement strategy.

Use the last six months of practice data to establish a baseline of revenue cycle performance in these areas. When establishing baselines, bear in mind that inclusion or exclusion of various case types may influence calculations for certain KPIs. For example, will rejected claims be included in claim denial rate formulas? The decision to include or exclude bad debt claims or payment plan accounts can similarly skew accounts receivable (AR)-related KPI calculations.

Track KPI performance at least monthly to begin with. This allows leadership to identify and intervene in failing performance areas early. Conduct a root cause analysis in areas of underperformance to understand month-to-month variations. When possible and where applicable, monitor KPI variation at the individual clinician level, at the aggregate practice level, and by payer for a granular view of potential problem areas.

**Table 1**

<table>
<thead>
<tr>
<th>Financial Metric</th>
<th>Definition</th>
<th>Industry Standard Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial Rate</td>
<td>% of total claims denied of total claims submitted</td>
<td>5–10%</td>
</tr>
<tr>
<td>Days in Accounts Receivable (AR)</td>
<td>Average number of days to collect payments due</td>
<td>30–0 days</td>
</tr>
<tr>
<td>% of AR &gt; 120 Days</td>
<td>% of AR on books &gt; 120 days from date of service</td>
<td>≤ 25%</td>
</tr>
<tr>
<td>Gross Collection Rate (GCR)</td>
<td>Total payments as % of total submitted charges</td>
<td>35–40%</td>
</tr>
<tr>
<td>Net Collection Rate (NCR)</td>
<td>Net payments minus contractual adjustments as % of total submitted charges</td>
<td>≥ 95%</td>
</tr>
<tr>
<td>First Pass/Clean Claim Rate</td>
<td>% of claims accepted on first submission out of total claims submitted</td>
<td>90–5%</td>
</tr>
<tr>
<td>Charge Lag Days</td>
<td>Average number of days between date of service and charge entry</td>
<td>≤ 7 days</td>
</tr>
</tbody>
</table>
Variable Factors
Practices can see deviation from industry standard benchmarks for a variety of reasons, some of which may be out of your control. Specialty, location, resources, and payer partners all influence financial KPIs. For example, subspecialties such as interventional cardiology or pediatric neurology typically field high-dollar surgical procedures that require prior authorization work. As a result, these specialties often experience high denial rates. Practices located in inner cities with large Medicaid patient volumes might anticipate low gross and net collection rates due to diminished patient propensity to pay.

Paper-based practices generally underperform compared to those using a practice management system (PMS) or electronic health record (EHR). Paper superbills typically take long process times and are susceptible to error. Thus, charge lag days are often high in these environments. This can lead to payment posting delays and denials, which have big impacts on cash flow. If claims are not processed correctly within a given payer’s timely filing criteria, money may be left uncollected.

Turnaround times also vary from payer to payer. Some payers may be slower in processing, adjudicating, and reimbursing claims than others. While this is not a rejection or denial, it does lead to a decrease in cash flow and a high number of days in AR. Administrators who notice this occurring should engage the payer or plan’s representative to discuss the situation. Understanding these outside influences is important in setting realistic performance improvement goals within the practice.

A Holistic Approach
Armed with insight into your financial performance thresholds, your administrators can implement a targeted process improvement strategy. Then, examine every aspect of the current billing process, focusing on the weakest performance areas first. Renewed emphasis on streamlining the following processes can increase your revenue starting today.

- Credentialing and enrollment. When leadership teams set up a new practice, one of the first things they must tackle is credentialing and enrollment for every physician and eligible provider with each insurance plan they accept, for each facility they practice in. Unfortunately, after initial setup, many practices tend to forget about it. If changes are made—for example, a new clinician is added, they now practice in a different location, or the payer itself changes some detail—things don’t line up, and your reimbursements can be frozen, sometimes for months. Dedicated in-house or outsourced credentialing expertise and support helps keep these items from slipping through the cracks.
- Eligibility verification. Validating up-to-date patient information is crucial to the revenue cycle process and making sure the practice gets paid. For some patient populations, like Medicaid-centric groups, best practices may warrant a patient data review at every visit. With Medicaid beneficiaries, for example, there is an increased chance for members’ managed care plans to shift from month to month. Perhaps

Your team can begin making strategic improvements to operational areas that will have the greatest positive impact on revenue and outcomes.
In an era of rapid change and a dizzying mixture of regulation and competition, providers must routinely determine where inefficiencies are occurring that plague profitability and sustainability. Only through a thoughtful diagnostic evaluation process can you implement changes that maximize time, staff, and other resources so your practice can operate at peak efficiency to achieve desired results today and in the future. The old ways of operating a successful healthcare business must evolve to keep pace.

Evolve to Keep Pace

Financial KPIs tell the story of your value proposition and differentiation to health plans and new and existing patients alike. Advanced financial analytics—ideally with real-time data insight, alert mechanisms, and easy-to-interpret dashboards—enable practice RCM teams to quickly note downward trends and take action to intervene. Investing in revenue cycle optimization efforts today, before layering in quality payment program initiatives, ensures that future plans are built on a solid foundation.

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Sreeram Mantha currently serves as chief operating officer for Advantum Health. He is an entrepreneur and technology business leader with nearly two decades of experience serving hospitals and healthcare providers.