Top 5 Things You Must Know ABOUT Increasing Your Medical Practice Revenue

Presented by medicalincome.com
In terms of complexity, NASA’S space program might be able to compete with medical practice revenue cycle management, but not much else could. We’re not saying it’s rocket science, but managing your medical practice revenue in today’s volatile regulatory environment is certainly more than an art. It is the science of navigating a complex, highly regulated web of rules: you are in the middle with the government and insurers on one side, and your staff, coders and patients on the other. Protecting your revenue means finding experts who can pay attention to this ever changing web so you can pay attention to your patients.

These days coding, claims and collections are becoming increasingly complex on a weekly basis. Regulations, reconciliation processes, and revenue management are running away with private practice physicians’ time. In fact, the American Medical Association estimates that the cost of inefficient health care claims processing, payment and reconciliation for private physician practices is between $21 billion and $210 billion. That comprises 10-14% of a physician’s practice revenue. We know that is money you cannot afford to lose.

Key to practice efficiency are the administrative processes that handle the claims revenue cycle. Practice revenue depends almost entirely on the skill and timeliness with which claims are handled. The complexities of ICD-10, if not handled correctly and in great detail by your staff, can create sink holes for your practice revenue. The best way to remove threats to your revenue stream is to remove uncertainty and variability by implementing a progressive revenue cycle management system. MICI will do just that: implement proven processes to increase the speed with which claims are paid, and as a result, the profitability of your medical practice.

Here are the top five things you must know about increasing your medical practice revenue:

1. To optimize profitability, you need speed
   a. *Precision and command of the details*
   b. *Increase patient pay*

2. It pays, literally, to know your insurance company
   a. *Know their ratings from the national report card*
   b. *Manage managed care contracts*

3. Learn to navigate the new frontier of ICD-10
   a. *The forecast isn’t pretty*

4. It takes empathy, knowledge and tenacity to get optimum revenue
   a. *We are the point of contact with your patients*
   b. *Know your patient, know your claim*

5. Take a tactical approach- Strategic deployment of technologies and denials defense
   a. *Think denials management and defense.*
   b. *Electronic strategies*

Continue reading for a detailed look at each of these issues!
If you look closely, you will see there is a distinct mismatch between the current system of claims processing by the payers, and the methodology with which doctors file claims. The myriad bottlenecks in these antiquated claim-payer-physician systems can keep revenue locked up and delayed. If your office systems cannot inform you of changes in payer claim requirements, you are losing time and money. If your claims do not fit the payer’s system, you will receive increasing numbers of denials.

The ability to obtain detailed information from your revenue management system is an important advantage. For example, if you are seeing increased denials, you need experts to tell you if the payer’s claims requirements have changed. Real time data can also help to increase patient pay. At the time of the appointment, your staff will be able to tell the patient what their insurances does or does not cover, and a patient pay schedule can be arranged on the spot.

Optimizing your claim profitability takes the experience, precision and diligence of seasoned revenue cycle management experts. There aren’t enough hours in the day for your staff to get up to speed on the demands of ICD-10, support the physicians and staff clinicians and serve the patients well. When our team works with your practice, they optimize reimbursement patterns, decrease fixed costs of in-house claims processing, and accelerate financial performance for the practice.

#1: Let’s start by discussing how you can optimize your claim profitability.
It’s important to know who you are working with. In fact, your revenue depends on it. Knowing the intricacies of different insurance carriers can make the difference between the successful processing of claims or rejections. Did you know that the American Medical Association publishes an annual report card of the claims revenue cycle activities of the major commercial health insurers and CMS? It reports the timeliness, transparency and accuracy of claims processing of these payers. We will use that information to improve your reimbursements.

For example, the report card shows:

1) The median time period in days, between the date the physician claim was received by the payer and the date the payer produced the first ERA.

   Our system tracks claims for you to speed them along the payment track. If your claim is not paid within the time we expect by the insurance company, it is flagged in our claims queue and we automatically check its status.

2. On what percentage of claim lines does the payer’s allowed amount equal the practice’s expected allowed amount?

   We look at every claim that is paid, and the amount paid. Do the paid fees match the expected fees? If not, we are tenacious - and fast- in tracking that down and getting you the full payment due and contracted for.

3. What percentage of claim lines submitted are denied by the payer for reasons other than a claim edit?

   We use the national report card to understand where errors in claims processing might occur, reconcile them, work to ensure the errors don’t recur, and get you paid.

That brings us to managed care contracts.

These contracts are complex and critically important. We bring the skill and diligence necessary to obtain, maintain and renegotiate strong managed care contracts for you. We do so with knowledge, strength and tenacity in equal parts.

Appeal and denial advocacy: when you receive a denial we are, literally, on the case. We are on top of every denial, every time. Pursuing denials takes time—time that physicians should be spending with patients.

We doggedly pursue denials until we find out precisely when and why the denial occurred and which ones can be prevented in the future.

What is the reason for the denial? Was it:

- Managed care contract paid incorrectly
- Appeals for information provided incorrectly
- Carrier denying for medical reasons
- Eligibility for the patient
- Or some other reason?

Then, we check the check! When a managed care contract payment is received, we verify it matches your expected fee for that service. If not, we’ll challenge the payer and go after the full payment you deserve.

We know the record on each individual insurance company and their standard length of time for payment. We hold them accountable to that time.
#3: Learn to navigate the new frontier of ICD-10.

October 1, 2015 is D-Day for implementation of ICD-10. That’s the day when coding expands exponentially. The forecast isn’t pretty.

The Centers for Medicare & Medicaid Services (CMS) estimates that in the early stages of implementation:

- Denial rates will rise by 100 to 200 percent
- Days in A/R will grow by 20 to 40 percent
- Claims error rates will be more than two times higher with ICD-10, reaching a high of 6 to 10 percent (compare to an average 3-percent error rate with ICD-9)
- A typical turnaround time for claims processing of 45 to 55 days could end up being extended another 10 to 20 days
- AHIMA reports that on average coders took nearly 18 minutes longer to code a record in ICD-10-CM/PCS than they did in ICD-9-CM.

The American Health Information Management Association (AHIMA) says the shift to ICD-10 will change the nature of denials and their management. Claims denials will not strictly be a matter of clarification that can be handled by a nonclinical person in the billing office.

According to AHIMA, “Denials will raise questions about medical necessity or the clarity of medical documentation supporting a code; such questions will require input from a physician, nurse specialists, or outside expertise.” Physicians are going to be required to become more involved in denials management.

This isn’t the time for the meek.

This is the time to bring in experts who can streamline your revenue cycle workflow for optimal profitability. This should be done with a multi-pronged approach that combines denials management, contract compliance, and coding and billing improvements and the strategic use of technology.
#4: It takes empathy and knowledge to optimize patient pay.

From now on, revenue cycle management best practices will integrate clinical care and financial information. That means that improving your revenue stream will require integrating clinical care decisions with an understanding of the patient’s ability to pay.

Patients need to understand their financial responsibility for care or a service. Physician’s need to understand payer requirements for tests and services.

At every stage of the billing cycle, MICI works to optimize claim profitability for physicians, while advocating for patients with care and respect.

We send your statements out on time, guaranteeing a consistent revenue stream. When your patients call with a question regarding their bill they speak directly to us. Our number is listed as your billing office. We provide this service for an important reason – it removes the onus of collections and difficult conversations from your staff. We are experts in politely explaining charges. We follow up with patients on bills that are due, patiently and respectfully discussing the charges with them.

In an age where more and more practices are focusing on patient satisfaction, we are your partner – a strong, reliable and empathetic partner.
#5: Strategic deployment of technologies and denials defense as part of speed

Have you taken full advantage of the internet and the computers in your office? Simply setting up the right electronic systems can streamline the capture of important patient and payer details, reduce errors and increase revenue. Our team will make sure that your practice takes advantage of every strategic technology that is compatible with your current IT office suite.

*Think denials management and defense.*

The strategic deployment of technology and online systems will help your practice manage the details necessary to submit accurate and complete claims. They will also help you to document in real time, the detailed patient information that you may need for future denials defense. For your practice we will consider electronic strategies that include:

- Eligibility verification
- Pre-scrubbing of claims before submission to payers
- Workers’ Compensation, Property and Casualty e-Billing
- E-filing to secondary payers

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**It’s a complicated world out there. It may help to know us.**

MICI is a medical practice support firm that handles the entire revenue cycle, including billing and collections, for doctors across the country. Founded in 1987, MICI has provided exceptional medical practice revenue cycle services to practices of all sizes, from small practices with one or two physicians to large groups with hundreds of physicians.

Beyond revenue cycle management, MICI provides services that enable physicians to focus on practicing medicine and healing patients. We don’t feel old, but together our team has more than 200 years of cumulative experience in medical practice support. MICI team members are diligent, thorough and tenacious—and always ready to take your call.

Our mission is to enable doctors to provide their best patient care. Our values include integrity, diligence, tenacity, loyalty, empathy, knowledge and progress.

At every stage of the billing cycle, MICI works to optimize claim profitability for physicians, while advocating for patients with care and respect.

Call us today at 281.580.9030. Getting money in the door, managing your practice and caring for your patients isn’t getting any easier, but we can help. We will pay attention to the revenue cycle so you can pay attention to your patients.
1: AMA http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/discussion-board.page, Administrative Simplification LinkedIn Group, nd, no author


