RCM Leadership:
Keys to Effectively Lead and Influence Successful Revenue Cycle Management Without Doing the Work Yourself
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Senior Consultant

Why is RCM so Important?
Protect Cash Flow for the Practice
Business Transactions
- Acquisitions, Mergers, Loans
Provider and Owner Earnings

Manager/Administrator’s Role
Generally not working with RCM directly
Responsible for managing business
Needs to identify when problems arise
Protect Cash Flow!
Must keep a pulse on RCM activity
Provides direction for other staff

Protect Cash Flow for the Practice
Manager Must Have the “Vision”

A manager provides the “VISION” of what’s important, whatever they focus on is what others will focus on.

What is our vision?

It is difficult to see what we are not looking for.

Manager Must Have RCM “Vision”

Manager provides the “vision” of what’s important; whatever they focus on is what others will focus on.

Manager needs to know processes involved for their RCM.

Manager must know policies.
Benefits of Knowing the Process

- Stay aware of potential issues
- Answer questions and provide guidance
- Process Improvement

Using Reports for Awareness

**What report measurements do you watch?**

- Aging A/R
  - Commercial older than 30 days
  - Medicare/Medicaid older than 30 days
  - Patient balances older than 90 days

- Net Collections Ratio
  - (Collections - Refunds / Charges - Adjustments)

- Denial Report (total denial percentage)

- Payer Mix

- Productivity Reports
  - Charges/RVUs/Encounters

Create a Dashboard
**Create a Dashboard**

### A/R Aging Report

<table>
<thead>
<tr>
<th>Month</th>
<th>0-30</th>
<th>31-60</th>
<th>61-90</th>
<th>91-120</th>
<th>&gt;121</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$106,083</strong></td>
</tr>
<tr>
<td>7%</td>
<td>10%</td>
<td>16%</td>
<td>4%</td>
<td>57%</td>
<td><strong>106,083</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$315,691</strong></td>
</tr>
<tr>
<td>30%</td>
<td>20%</td>
<td>20%</td>
<td>8%</td>
<td>19%</td>
<td><strong>315,691</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Commercial</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$677,631</strong></td>
</tr>
<tr>
<td>21%</td>
<td>30%</td>
<td>14%</td>
<td>9%</td>
<td>26%</td>
<td><strong>677,631</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$1,103,305</strong></td>
</tr>
<tr>
<td>22%</td>
<td>27%</td>
<td>16%</td>
<td>8%</td>
<td>27%</td>
<td><strong>1,103,305</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Payer Mix**

![Graph showing payer mix over time]
Answer Questions – Provide Guidance

As a manager, you don’t do everything, but you should be able to problem solve and direct staff.

Case Scenario – Over Past 6 Months
— Reports show productivity up 10%
— revenue up 2%
— Change in billing manager around the same time
— New practice management system in last few months
— No new contracts or change in service mix

Process Overview

Questions:
— Are payers receiving all the claims?
— Are all claims being received by clearinghouse?
— Review denials for trends?
— Were all fee schedules entered to new system correctly?

Answer Questions – Provide Guidance

Thought process for correction

— Collect co-pays/deductibles
— Document visit
— Assign DX and CPT/HCPCS codes
— Collect additional fees
— Schedule follow-up appointment
— Charges captured and entered on charge sheet or EMR by MD and/or other providers
— Charges entered into PMS
— Claims submitted by office
— Claims scrubbed
— Claims transmitted to payers by clearinghouse
— Patient statements
— Receive EFT postings
— Hand post payments
— Review EOB for accuracy
— Schedule appointment
— Collect patient demographics
— Obtain and verify insurance information
— PA approval

Financial Reporting

— Accounts receivable reviews
— Monthly financial reports
— Insurance/third-party accounts
— Patient accounts
— Adjustments, write-offs, refunds
— Follow up with denials or slow payments
— Account receivable receivables
— Identify financial metrics

Payment Posting

— Insurance/third-party accounts
— Patient accounts
— Adjustments, write-offs, refunds
— Follow up with denials or slow payments

Claim Submission

— Insurance/third-party accounts
— Patient accounts
— Adjustments, write-offs, refunds
— Follow up with denials or slow payments

Scheduling / Insurance Verification

— Schedule appointments
— Collect patient demographics
— Obtain and verify insurance information
— PA approval

Visit / Documentation Coding

— Code medical history
— Document visit
— Enter ICD and CPT/HCPCS codes

Checkout / Charge Entry

— Collect additional fees
— Schedule follow-up appointment
— Charges captured and entered on charge sheet or EMR by MD and/or other providers
— Charges entered into PMS

Claim Submissions

— Claims submitted by office
— Claims scrubbed
— Claims transmitted to payers by clearinghouse
— Patient statements
— Receive EFT postings
— Hand post payments
— Review EOB for accuracy
— Schedule appointment
— Collect patient demographics
— Obtain and verify insurance information
— PA approval
Where’s the money?

Case Scenario:
— Neurologist practice
— Outsourced billing company
— Says his revenue is down and doesn’t know why
— A/R aging buckets are high for 90 days and above
— Much of the aging A/R is for commercial payers

Findings:
— Claims just being resubmitted
— No denied claims report
— Request billing company to focus attention on denials and find out why. Communicate back to fix errors

Process Improvement

Interpreting the Denial Report

<table>
<thead>
<tr>
<th>Denial Code / Reason</th>
<th>Count</th>
<th>%</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>468 – DUPLICATE CLAIM</td>
<td>9</td>
<td>8.74%</td>
<td>$1,575.00</td>
</tr>
<tr>
<td>467 – NO PRECEPT OR PRIORAUTH</td>
<td>15</td>
<td>14.49%</td>
<td>$3,325.00</td>
</tr>
<tr>
<td>597 – NOT PRIMARY PAYER</td>
<td>15</td>
<td>14.49%</td>
<td>$2,625.00</td>
</tr>
<tr>
<td>390 – PATIENT NOT INSURED BY PAYER</td>
<td>14</td>
<td>13.59%</td>
<td>$2,450.00</td>
</tr>
<tr>
<td>897 – FREQUENCY OF SERVICE</td>
<td>7</td>
<td>6.80%</td>
<td>$1,225.00</td>
</tr>
<tr>
<td>320 – PROVIDER NOT ENROLLED</td>
<td>15</td>
<td>14.49%</td>
<td>$2,625.00</td>
</tr>
<tr>
<td>629 – SERVICE IS NOT COVERED</td>
<td>7</td>
<td>6.80%</td>
<td>$1,225.00</td>
</tr>
<tr>
<td>444 – TIME LIMIT FOR FILING EXPIRED</td>
<td>4</td>
<td>3.88%</td>
<td>$700.00</td>
</tr>
<tr>
<td>532 – NOT AUTH NETWORK/PRIMARY PROV</td>
<td>7</td>
<td>6.80%</td>
<td>$1,225.00</td>
</tr>
<tr>
<td>444 – MULTIPLE PROCEDURES ON SAME DG</td>
<td>4</td>
<td>3.88%</td>
<td>$700.00</td>
</tr>
<tr>
<td>OTHER</td>
<td>2</td>
<td>1.94%</td>
<td>$350.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>103</td>
<td></td>
<td>$16,825.00</td>
</tr>
</tbody>
</table>
Process Improvement

- **Review Denial Report and Identify Reasons**
  - Provider not enrolled identified as item of concern.

- **Educate**
  - Notify the staff which health plans the provider is not enrolled with.
  - Don't schedule appointments with patients that have these plans or schedule with a different provider.

- **Modify Procedures**
  - Identify a way to track enrollment process.
  - Escalate pending insurance plans that are still pending.
  - Verify correct enrollment applications have been sent to every health plan.

- **Review Provider Enrollment Process**
  - Provider is not enrolled with some insurance plans.
  - There is not a good tool for tracking the enrollment process.
  - Staff is not aware of what insurances are not enrolled.

Case Scenario

A/R aging report is benchmarked below average

- Meet with billing manager:
  - He/she understands the basics.
  - Staff are assigned based on patients names for posting and A/R follow up.
  - Manager needs help to dive deeper.

**What questions to ask?**

- What gets worked on when?
- Are there strengths of staff?
- Review each process in cycle to ensure staff are competent in each area.

Possible Results

- Identify potential problems
- Provide additional training
- Improve the process through PI effort

Manager has not done the work, but has helped identify issues and solved the problem.
Different Payment Models

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Question 1</th>
<th>Question 2</th>
<th>Question 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>Is the payment received for each service what we are contracted for?</td>
<td>Are we getting paid for all of the patients we see in our practice?</td>
<td>Do we have a cash pay policy and collect accordingly?</td>
</tr>
<tr>
<td>Capitation</td>
<td></td>
<td></td>
<td>Are we able to track and report on metrics we are paid for?</td>
</tr>
<tr>
<td>Cash Pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value / Quality Based</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary:

- Managers must have a good knowledge of RCM — they set the tone for how it is handled.
- Managers create the “vision” of what we should be focusing on.
- Stay aware of potential issues with your RCM to avoid cash flow problems.
- Be prepared to answer questions from staff and to provide guidance when needed.
- Use awareness and expertise to guide process improvement within RCM departments.
Thank you!

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