

Clean Up Your Revenue Cycle Now: 6 Survival Tips for ICD-10–Induced Payment Slowdowns

Cheryl L. Toth, MBA

You have read the scary headlines and dire predictions about ICD-10 claim submission complications and cash-flow crunches. What are you doing to avoid a near-certain slowdown in your revenue cycle this fall?

Assessing and improving specific areas of the revenue cycle cannot only mitigate the risk of ICD-10–induced cash shortages. It can also improve the overall health of your billing and collections processes, resulting in faster payments with fewer problems. Use these survival tips to develop and

maintain a solid revenue cycle in preparation for October 1 and beyond.

1 Be brilliant on the basics. With so many predicted payment system problems, you cannot afford to overlook the basic elements of an efficient, well-managed revenue cycle. Do not assume your current systems are flawless. Be sure the practice can answer “yes” to these **basic** revenue cycle elements. If not,

Our Practice...	Yes	No
1. Pre-registers at least 90% of all new patients through a patient portal or by phone.		
2. Re-registers every established patient who is seen in the office, by verifying and/or updating demographic and insurance information in the computer.		
3. Verifies eligibility and benefits for all new and established patients, every day, and prior to every surgery.		
4. Knows which procedures require precertification or preauthorization; staff obtain these 100% of the time it is required.		
5. Posts all office visit services by end of day.		
6. Posts all surgeries and hospital services within 48 hours.		
7. Electronically submits claims every day.		
8. Reviews and corrects claims that hit the clearinghouse “front end edit” report every day, then resubmits the corrected claims that same day.		
9. Is automatically alerted or can easily identify plan underpayments because payor reimbursement schedules are entered in the computer system.		
10. Has Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) for as many plans that offer it.		
11. Uses online tools for precertification, preauthorization, and unpaid claim status.		
12. Has created detailed adjustment categories (eg, “Patient not eligible,” “No prior authorization obtained”) to monitor denial patterns and fix process problems.		
13. Scans all Explanation of Benefits (EOB) forms into the computer system to allow easy access to the data; paper EOBs are shredded.		
14. Generates patient statements on the same day the insurance payment is posted – NOT on a monthly or bi-monthly billing cycle.		
15. Maintains an average “days in receivable” (the average number of days it takes to receive payment on an account) of 30-45 days.		
16. Maintains an average of 15% or less of all receivables over 90 days old.		
17. Maintains a collection ratio (the percentage of collectible money, not adjustments, that is actually collected) of 95% or higher.		

Ms. Toth is Consultant, KarenZupko & Associates, Chicago, Illinois.

Address correspondence to: Cheryl L. Toth, KarenZupko & Associates, 625 N. Michigan Ave., Suite 2225, Chicago, IL 60611 (tel, 312-642-5616; fax, 312-642-5571; e-mail, ctoth@karenzupko.com).

Author’s Disclosure Statement: The author reports no actual or potential conflict of interest in relation to this article.

Am J Orthop. 2014;43(5):205-208. Copyright Frontline Medical Communications Inc. 2014. All rights reserved.

take action on as many as you can over the next few months. The more efficient the overall revenue cycle process, the fewer opportunities for claims submission delays, avoidable denials, and overdue accounts receivable.

2 Recognize and plan for ICD-10 prior authorization issues.

Because medical necessity for all surgeries after October 1 must be described using ICD-10, and prior authorizations are typically done 3 to 4 weeks before surgery, orthopedic practices must learn the new system at least 3 or 4 weeks ahead of October 1. And if your procedure schedule is booked months in advance, your practice may be required to preauthorize (and precertify) using ICD-10 as early as this summer.

Failure to process prior authorizations correctly can result in denials and/or no reimbursement at all. Make sure you have scheduled training accordingly and implemented any new preauthorization planning forms and processes. Also, check payor sites to determine how date of service and date of discharge affect which system to use for procedures scheduled close to October 1.

3 Clean up 90- and 120-day-old insurance receivables.

Over the summer and into the fall, stress to your staff the importance of collecting overdue insurance receivables. The cleanup will not only enhance your bank account, it will give the billing team more time to deal with transition planning and testing before October 1—as well as the potential deluge of claim denials and technology glitches after that date. If you can hire an experienced biller or collections specialist to conduct this cleanup on a project basis, it will be money well spent. In fact, based on predicted ICD-10 productivity slowdowns, you would be smart to keep someone capable on staff through early 2015 to supplement your existing team.

Approach these overdue account balances strategically: target the highest balances first. Here's an effective way to organize the project:

- Generate an accounts receivable (A/R) report by payor, listing account detail for each patient who has an outstanding balance with that payor. (Most systems can do this.)
- Generate this report in descending balance order, if your system is capable of this. Or...
- Export the report into Excel and sort the balance column in descending order.
- Instruct staff to start with the largest balance and work their way down the list.

Armed with the data in descending balance order, your staff or a capable temporary worker can look up each claim online and call payors as needed. Make sure the staff document all actions in each patient's account "comments"—including dates, names, and details about insurer remarks.

Good notes enable someone else on the team to easily pick up where a coworker left off.

At the end of each month, review the results of the highest 10 account balances. Set a goal to have the insurance A/R cleaned to the point that no more than 10% of all payor receivables are less than 90 days old on September 30.

4 Launch a summer patient collections campaign.

According to a 2009 survey by McKinsey & Company¹:

- 74% of patients said they were willing and able to pay out-of-pocket expenses less than or equal to \$1,000, and 62% were willing to pay medical bills greater than or equal to \$1,000.
- 37% of patients said that a lack of payment options was the reason they didn't pay health care bills.

Use the ICD-10 deadline as a collections opportunity. Launch a campaign to help patients pay off their bill before October 1. Proactive follow-up on overdue patient accounts can be productive. If you provide convenient tools and options, the chance of collecting on patient accounts can skyrocket.

Direct staff or a temporary worker to organize the project by prioritizing follow-up in descending balance order. Then tell them to pick up the phone and call the patient. This may seem old-fashioned in today's digital world. However, building rapport over the phone significantly increases the chance that staff and patients agree about how to settle the account. Consider offering patients incentives to pay off their bill. For example:

- "Mrs. Jones, your account balance is \$965.43. If you pay in full by the

5 Critical ICD-10 Revenue Cycle Tasks That Should Already Be Done

- 1. Secured a line of credit.** Reputable sources predict increased denial rates and slower payment processing. A line of credit helps mitigate this risk.
- 2. Identified, analyzed for their revenue impact, and crossed to ICD-10** the practice's top 25 to 50 diagnosis codes.
- 3. Evaluated and updated all forms and processes that involve or are impacted by diagnosis codes.** These include encounter forms (Superbills), preauthorization letter templates, presurgical cost quotation forms, test ordering forms, surgery scheduling sheets, etc.
- 4. Tested and verified that all software vendors, clearing-houses, and major payors can receive and pay claims in ICD-10.** If testing is not complete, the practice at least has a list of which vendors and payors remain and the upcoming testing dates.
- 5. Completed training for all staff and physicians.** Physicians, nonphysician providers, and all billing and coding staff understand the details required and can select ICD-10 codes. It is important that 50% of visit dictation, operative notes, preauthorization letters, and claims are being completed in both ICD-9 and ICD-10 to practice.

end of the week, we will take \$100 off the total. Would you like to pay by credit card or online?

- “Susan, we understand it can be difficult for patients who have high deductibles like yours. So our physicians are offering a 20% discount if you pay your overdue balance in full, or a 10% discount if you set up a plan with \$200 today, and 3 installments over 90 days.”

Offering payment technologies and options increases convenience and the chance patients will pay. Three essential tools used by modern practices are:

- **Online bill pay.** If you offer this, promote it heavily. If you do not, contact your practice management system vendor. Most offer a patient portal with this feature. Alternatively, solutions from TransFirst (www.transfirst.com) or PayPal are easy to implement.
- **Automatic recurring payments.** Paper vouchers and payment books are things of the past. Just as consumers pay for gym memberships and monthly Netflix subscriptions, practices can offer automated payments by credit card. These require a one-time setup and virtually no ongoing management by your staff. TransFirst (www.transfirst.com) and PayPal both offer an automatic, recurring bill-pay feature. Some patient portal products do too.
- **Patient financing.** CareCredit (www.carecredit.com) offers a health care credit card that allows patients to finance deductibles, coinsurances, and other out-of-pocket expenses, and your money is off the books and in the bank in 2 business days. Better yet, CareCredit assumes the credit risk and handles the collections with the patient directly.

5 Retool patient financial policies.

Data show that only 10% of patients' financial obligation is collected prior to or on the date of service. Most practices still wait until the insurance company has paid before sending the first patient statement, which often becomes the first of 3, 4, or 5 statements. Assuming the average cost of sending a statement is \$5 to \$8, and your practice waits 30 days for insurance payment, and then sends 3 statements to receive payment, you are paying \$15 to \$24 to wait 120 days for your money. If the balance is less than \$25, you have not only waited, you have lost money.

Modern practices collect at time of service and prior to the patient's surgery date. If there is a prior balance, they ask patients to pay it when they arrive for an appointment during the 90-day global period. They proactively work with patients to set up payment plans, and they have clear policies

and procedures for the growing number of patients who have high deductibles or are out of network.

Online cost estimators are free technology tools offered by payors that deliver patient copay and deductible data at the point of service. They are essential tools for collecting at the time of service and for having financial discussions with patients prior to surgery. Staff enter CPT codes and the patient's benefit information into the online cost estimator,

Availity CareCost EstimatorSM
Member Responsibility Calculation Results [FAQs](#)

E & B Results | Edit CareCost Estimator Inquiry | Print Provider View | Print Patient View

Patient Name: _____ Service Provider: _____
 Member ID: _____ Plan Name: Choice Fund HSA Open Access Plus
 Service Date: 01/11/2013 Estimate Benefit/Service Type: 50 - Hospital - Outpatient
 In Network: Yes

Procedure Details

Procedure Code	Description	Cost of Service
27828	TREAT LOWER LEG FRACTURE	\$1,439.20
20694	REMOVE BONE FIXATION DEVICE	\$488.51

Estimate (as of 01/11/2013)

	Cost of Service	Deductible Responsibility	Co-Ins	Co-Pay	Estimated Member Resp	Anticipated Health Account Payment	Estimate of What Member Owes
Total	\$1,927.71	\$1,868.96	\$11.75	\$0.00	\$1,880.71	\$0.00	\$1,880.71 Collect Payment

Figure 1. Cost estimators like the one offered by Availity (www.availity.com) deliver estimated patient responsibility data in seconds and enable staff to collect more at the point of service.

and the amount the practice can collect from the patient is delivered in seconds. Data are specific to the patient's insurance-plan benefits and provide the exact amount that can be collected in the office.

Access to this detailed cost data allows your staff to confidently ask for payment of office services before they leave—and improves presurgical conversations about deposits and payment plans.

Many insurance plans offer cost estimators on their web sites. Others deliver the data through statewide or regional portals such as Availity (www.availity.com; **Figure 1**). Train your front-desk and financial counselor how to use them to collect copays and deductibles before patients leave the office.

6 Increase transparency, increase collections.

For decades, we have advised clients and workshop participants to use cost quotation worksheets that explain each surgical patient's financial responsibility. Patients who receive this information are much more willing to pay than those who are left in the dark about costs until they see their first statement.

In addition to online cost estimators, tools such as the free, third-party *Coverage Calculator* (www.coveragecalculator.com).

com) do the same math but more quickly than cost quotation worksheets. They also allow patients to run financial scenarios for other health care services (Figure 2). Coverage Calculator was founded by James Weintraub, MD, to help staff talk with patients about outstanding balances. Enter plan-

allowable data and patient-specific information, such as coinsurance and deductible (available on most payor portals), and the Coverage Calculator instantly calculates what patients owe your practice.

Conclusion

As the ICD-10 deadline approaches, shore up your revenue cycle to prepare for potential post–October 1 payment slowdowns. Be brilliant on billing process basics. Clean up old receivables this summer. Start the collections process earlier, instead of after insurance has paid. Adopt online payment tools that improve cost transparency and automate processes, saving precious staff time and reducing the overall cost of collections.

Reference

1. Finn P, Pellathy T, Singhal S; for McKinsey & Company. U.S. healthcare payments: remedies for an ailing system. *McKinsey on Payments*. 2009;(4):40-47. http://www.mckinsey.com/App_Media/Reports/Financial_Services/US_healthcare_payments_Remedies_for_an_ailing_system.pdf. Accessed March 12, 2014.

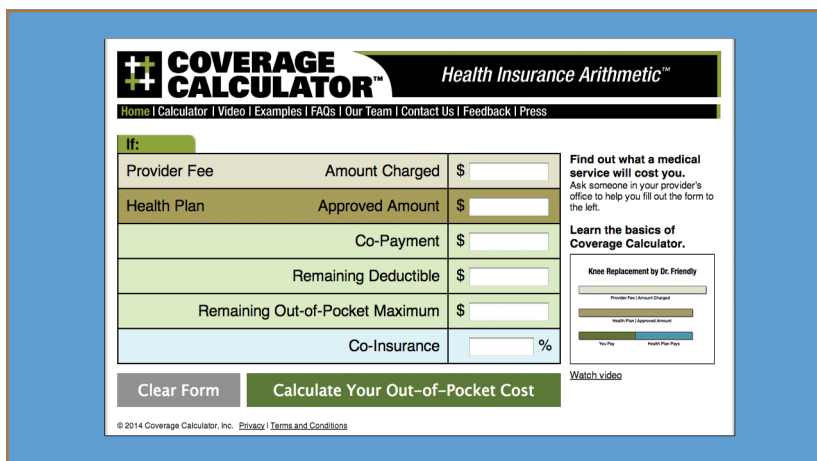


Figure 2. Coverage Calculator helps practices have open conversations about costs. Developed by a surgeon, it’s free for practices and patients: www.coveragecalculator.com.