REVENUE CYCLE MANAGEMENT

Streamline your practice's revenue collection.

BY NICHOLAS BENEDICT

The relative complexity of collecting revenue for medical services has given rise to a set of practices known as *revenue cycle management* (RCM). The aim of RCM is to improve the ability of a medical practice to collect funds owed to it.

There are three primary benefits of an effective RCM system:

- No. 1: Increased collection (ie, fewer denied claims by insurers);
- No. 2: Reduced need for working capital (ie, faster collection of revenue); and
- No. 3: Decreased costs due to increased efficiency in revenue collection processes.

An RCM system touches several aspects of a practice's operations. It begins with patient registration and scheduling and includes insurance verification, copay collection, Current Procedural Terminology and International Classification of Disease code entry, and claims management, including insurance denials and patient billing follow-up.

RCM FOR INDEPENDENT PROVIDERS: WHY NOW?

Until recently, most adopters of comprehensive RCM systems were large hospitals and organizations with multiple facilities. I use the term *comprehensive* here because some elements of RCM, such as bad debt collection, have frequently been outsourced on a piecemeal basis by large and small facilities for quite some time.

As regulatory burdens are increasing, insurers' requirements are growing more stringent. As competition from large and consolidating players increases, independent providers may find the environment for revenue collection more challenging. A 2018 Physician's Foundation survey indicated that the number of doctors owning independent practices was halved in 2019 because many practices shut down.[1]

RCM helps providers navigate some of the aforementioned challenges. As one industry observer explained, "The difference between effective [RCM] and ineffective [RCM] is success or failure in the industry."[2]

THE MARKERS OF AN EFFECTIVE RCM SYSTEM

RCM is not a discrete software package that one can simply purchase and forget. RCM is a set of procedures often managed through software to improve revenue collection. There are significant drawbacks to outsourcing RCM for many practices.[3]

Automated patient information collection and verification. When thinking about implementing RCM practices or software or working with a vendor to do so, one key principle to remember is that effective RCM begins when a patient first books an appointment. It is much easier to obtain—and verify—crucial billing information up front than it is to chase it down later or, worse, to correct errors when addressing insurance denials.

Automated coding and revenue collection. In addition to up-front systematic and automated patient demographic and insurance information collection, effective RCM systems generally also include automated International Classification of Disease and Current Procedural Terminology coding and client billing and technology-enabled revenue collection from copays and third parties.

A robust reporting module. Great RCM systems include a robust reporting module so that gaps can be quickly identified and addressed.

Value-based care analytics. With the Medicare Access and CHIP Reauthorization Act of 2015, the shift to value-based care (and reimbursement) in the United States is well underway.[4] An effectively designed RCM system includes analytics that allow payers and providers to access some of the data required in a value-based care system, which should help independent practices thrive as they enter this model.

CONCLUSION

Effective RCM can produce measurable and significant gains. There are no independent studies that benchmark the return on investment for RCM in independent practices. However, one RCM software provider reported an average 31% increase in net income collection as a result of its services.[5] As a secondary benefit, revenue also arrives more quickly with the use of RCM, and generally fewer staff hours are wasted on tedious tasks such as reminding patients of scheduled appointments, following up to collect balances, and addressing and disputing claims denials. ■

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